State of California—Health and Human Services Agency
Department of Health Care Services

DAVID MAXWELL-JOLLY
Director

ARNOLD SCHWARZENEGGER
Governor

July 22, 2010

Dear Interested Parties:

CALIFORNIA CHILDREN'S SERVICES (CCS) PROGRAM REQUEST FOR APPLICATION (RFA) 10-100 PRE-PROPOSAL BULLETIN 1

The California Department of Health Care Services (DHCS), California Children's Services (CCS) Program is requesting your comments and recommendations on the attached **DRAFT** "Request for Application" (RFA) that will be used for qualified entities to submit an application for a contract with DHCS to provide health care services to children with special health care needs and who are eligible for the CCS Program, under one of four proposed pilot models

Under the Social Security Act, Section 1115, Research and Demonstration Projects, the Department will pilot four models of care for children enrolled in the CCS program. By testing multiple models of care, California believes it will be able to create health care delivery systems that respond to the unique needs of regions and populations throughout the state. The pilots will also help inform best practices, through a comprehensive evaluation component, so that at the end of the five-year demonstration period decisions can be made on possible permanent restructuring of the CCS program design and delivery systems. The four models of care for the CCS program to be piloted include:

- An Enhanced Primary Care Case Management (EPCCM) Program;
- A Provider-based Accountable Care Organization (ACO);
- A Specialty Health Care Plan (SHCP); and
- Utilization of existing Medi-Cal Managed Care Plans.

The **DRAFT** RFA details the expected contractual responsibilities of each of the models of care and delineates many of the materials that will need to be provided to the Department in support of their application. The content of the document and the procurement process is subject to change, pending approval of the 1115 Waiver Amendment by federal Centers for Medicare and Medicaid Services, passage of the FY 2010-11 Budget and the enabling legislation identified in Senate Bill 208, Section 5 and Assembly Bill 342, Section 5.

The Department is also requesting Interested Parties to submit a Voluntary Letter of Intent in addition to comments on the **DRAFT** RFA. While Voluntary Letters of Intent to submit an application in response to the RFA are not required, DHCS is

interested in knowing which model or models your firm would be interested in implementing.

Please understand that this is not a solicitation for applications at this time but is designed only to solicit comments and elicit information for consideration regarding the content of the **DRAFT** RFP components.

Comments are due to the Department by **August 23, 2010** and should be submitted to the following mailbox:

omcprfp6@dhcs.ca.gov

In addition, please continue to monitor the OMCP website for updates to this RFA. The website address is:

http://www.dhcs.ca.gov/provgovpart/rfa_rfp/Pages/OMCPHomePage.aspx

Sincerely,

Original Signed by *Kevin Morrill*

Kevin Morrill, Chief
Office of Medi-Cal Procurement

DRAFT Request for Application #CCS-1

California Children's Services Pilot Programs
In support of implementation of the 1115 Waiver

California Department of Health Care Services
Office of Medi-Cal Procurement
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Request for Application CCS-1

TABLE OF CONTENTS

5. Provider network
6. Scope of services
7. System requirements
8. Reimbursement

D. Medi-Cal Managed Care Plan
1. Description
2. Qualified entities
3. Eligible population
4. Service areas
5. Provider network
6. Scope of services
7. System requirements
8. Reimbursement

IV. Core Requirements of all Demonstration Models

A. Family-Centered Care
B. Service Network and Access to Care
C. Scope of Services
D. System Requirements
E. Rights and Responsibilities of enrolled children/youth and families
F. Enrollment
G. Quality Monitoring and Improvement Measures
H. Data Reporting and Management Information System (MIS)
I. Administrative Responsibilities
J. Financial Responsibilities
K. Accountable Care Organization
L. Specialty Health Care Plan or Medi-Cal Managed Care Mod*el*
M. Reimbursement
N. Evaluation of Pilot Projects

V. RFA Application

A. Application Process
1. Letters of Intent
2. Applicants' Conference
3. Application Submission Instructions
4. Application Format
5. Application Content

B. Evaluation Process

1. Evaluation and award process
2. Evaluation criteria
   - Application Capability
   - Work plan

- Advisory board
- Family-Centered Care
- Service Network and Access to Care
- Scope of Services
- System Requirements
- Rights and Responsibilities
- Enrollment/Disenrollment
- Informational Materials
- Data Reporting
- Administrative Responsibilities

3. Contract Award and Protest Procedures
4. Interpretation of Contract

I. INTRODUCTION AND GENERAL INFORMATION

A. Purpose

The California Department of Health Care Services (DHCS), California Children's Services (CCS) Program invites qualified entities to submit an application for a contract with DHCS to provide health care services to children with special health care needs, who are eligible for the CCS Program, under one of four proposed pilot models.

As mandated in Welfare and Institutions Code Section 14180 et. seq, California's goal is to improve coordination of care in order to provide high quality, cost-effective care to the state's most medically vulnerable children, those with special health care needs. California's core purpose in piloting the redesign of the CCS program is to test innovative health care delivery models for transforming health care services for children with CCS conditions. The objective is to identify the model or models that will result in a well-integrated, coordinated and value-based health care delivery system.

Under Section 1115 Research and Demonstration Projects of the Social Security Act, the State of California will pilot four models of care for children enrolled in the CCS program. By testing multiple models of care, California believes it will be able to create health care delivery systems that respond to the unique needs of regions and populations throughout the state. The pilots will also help inform best practices, through a comprehensive evaluation component, so that at the end of the five-year demonstration period decisions can be made on permanent restructuring of the CCS program design and delivery systems.

The four models of care for the CCS program to be piloted include:

- An Enhanced Primary Care Case Management (EPCCM) Program;
- A Provider-based Accountable Care Organization (ACO);
- A Specialty Health Care Plan (SHCP); and
- Utilization of existing Medi-Cal Managed Care Plans.

The models proposed in this demonstration are designed to preserve the strengths of the current CCS program such as the standards for participating providers and access to the regionalized system of qualified sub-specialists and tertiary care providers who treat children and youth with conditions that require specialized care. These approaches incorporate the core concepts of organized delivery systems into the care received by children and youth below 21 years of age with special health care needs (i.e., CCS-eligible children and youth). Responsibilities and incentives for specialty and non-specialty care will be better integrated and aligned to promote clearer accountability, better care coordination, more effective and efficient use of public dollars, and improved health care outcomes. Family-centered care coordination will be provided in a way that streamlines the care delivery process and

provides more flexibility to ensure that the most appropriate care is provided at the right time, in the right place and by the right provider.

By the end of the waiver demonstration period, children and youth enrolled in the demonstration and their families are expected to experience better clinical outcomes, improved functional status, and greater satisfaction with their care experiences. Once these improvements are fully implemented they are expected to increase the per dollar value and reduce the rate of annual growth of expenditures on children and youth enrolled in the demonstration.

This Request for Application (RFA) process aims to identify entities, with the requisite qualifications and resources, to provide a range of health care services to CCS clients under the authority contained within the renewal of the Medi-Cal 1115 Hospital Financing Waiver. The process described within this RFA will require applicants to submit information and documentation, detailed in the RFA, which DHCS will evaluate against published criteria. These criteria appear in RFA Section ***TBD*** Evaluation.

B. Background Information

Children and Youth with Special Health Care Needs (CYSHCN) who are served by California Children's Services (CCS) program only receive medical services through the program for treatment of their CCS-eligible medical condition. The CCS program annually serves 175,000 to 200,000 children, 75 percent of whom are also Medi-Cal eligible beneficiaries. The expenditures for this latter population's medical services totaled $1.7 billion during FY 2008-09.

The CCS program is designed for the CYSHCN population which have complex, chronic and often disabling medical conditions, such as cancer, diabetes, cystic fibrosis, cerebral palsy, congenital anomalies and conditions secondary to premature birth. The CCS program has developed quality standards for pediatric specialty care and standards for approval of individual providers and facilities for participation in the program. Since the 1960s the CCS program has supported the concept of Special Care Centers (SCCs), multi-specialty, multi-disciplinary teams providing care to children with a defined set of medical conditions. These centers, located at tertiary medical centers, provide staffing and services according to program standards.

Financial eligibility for the program limits participation in the program to children and youth enrolled in the Medicaid program (Medi-Cal), Healthy Families Program (HFP), or whose families who have an annual income of $40,000 or less (these individuals are enrolled in what is referred to as the CCS State-only program). Currently sixty percent of the CCS-enrolled children and youth who are Medi-Cal beneficiaries are enrolled in Medi-Cal managed care plans. For the majority of these individuals, the treatment of CCS-eligible medical conditions is carved-out of the health plan's contractual obligation. Exceptions to the managed care carve-out are the three county-organized health systems (COHS) operating in eight counties, five

of which are at risk for the cost of treatment for CCS-eligible conditions. In these latter five counties, the county CCS program continues to perform its role of eligibility determination and service authorization. The remaining 40 percent of Medi-Cal children and youth enrolled in the CCS Program receive all of their care through the fee-for-service (FFS) system.

Children and youth enrolled in the HFP and identified by their managed care plans as potentially having a CCS-eligible condition are referred to the local CCS program to determine medical eligibility. If the local CCS program determines the child or youth is eligible for CCS, services to treat the CCS condition are generally authorized and provided by the CCS program and its paneled providers. Healthy Families Program managed care plans are responsible for providing, and paying for, all other medical care the child or youth needs that is unrelated to the CCS condition. This segregated approach makes coordination of care complicated and limits the ability of the managed care plan and the child or youth's CCS providers to have a comprehensive understanding of the client's total health care needs.

Children or youth enrolled as CCS-only (those not eligible for either Medi-Cal or HFP) receive only the services required for the treatment of CCS-eligible conditions and receive these services on a FFS basis. These children or youth may or may not have other health coverage that pays for some of their CCS services and/or other medically necessary services not related to their CCS-eligible condition.

The CCS Program currently uses a FFS payment structure administered through the Department's Fiscal Intermediary. This financing structure limits opportunities to incentivize providers to use lower-cost settings of care, when appropriate, for the child or youth. The teams at Special Care Centers are able to bill, on a fee-for-service basis, for team meetings and for assessments of children or youth and their families by physicians, clinical nurse specialists, nutritionists and social workers, in addition to medical services.

The CCS-carve out, where coverage for CCS-related conditions is provided separately from a child or youth's other medical care needs, has been identified by an array of stakeholders including families, CCS county staff, providers and DHCS and HFP staff, as a barrier to effective coordination of care and may detract from children and youth's health outcomes. The current CCS Program creates structural barriers and financial disincentives to providing "the right care at the right time in the right place." Parents and providers have noted that the CCS Program should serve the "whole child" and that segregating care for the CCS condition from a child or youth's total health care needs perpetuates fragmentation. Stakeholders have further noted that a lack of coordination between CCS providers and other providers in contracted health plans (or within the FFS system) delays or potentially prevents the delivery of patient-centered care.

C. Goals and Objectives

The overarching goal of the demonstration project is to identify the model or models of health care delivery for CCS children or youth that result in achieving the desired outcomes related to timely access to care, improved coordination of care, promotion of community-based services, improved satisfaction with care, improved health outcomes and greater cost-effectiveness.

1. **Goal 1:** To ensure that children and youth with special health care needs (CYSHCNs) in California have access to timely and appropriate, high quality and well-coordinated medical and supportive services that maintain, enhance and restore their health and functioning.

2. **Goal 2:** To reduce the annual rate of growth of expenditures for children and youth enrolled in the CCS program.

3. **Goal 3:** To increase satisfaction with the delivery of services provided through the CCS program among CYSHCN and their families.

4. **Goal 4:** To increase satisfaction with both the delivery of and the reimbursement of CCS services among providers who serve CYSHCN and their families participating in CCS.

5. **Goal 5:** To improve the State's ability to measure and assess what strategies are most and least effective in improving the cost-effectiveness of delivering high-quality, well-coordinated medical and supportive services to CYSHCN.

6. **Goal 6:** To increase the use of community-based services as an alternative to inpatient care and emergency room use.

II. PRINCIPLES

A. General

1. Enrollment in the models is mandatory.

2. Services covered under a contract will be based on the current range of Medi-Cal benefits available to individuals under 21 years of age.

3. Care coordination will be a required service.

4. Network requirements will be established that include CCS paneled providers and continuation of the regionalized service delivery system.

5. All contractors will be required to participate in a statewide quality improvement collaborative.

6. Each enrolled child or youth will have a medical home.

7. Quality monitoring and improvement measures will be consistent across models although the process for data gathering will vary by model.

B. Family-Centered Care

Family-centered care is based on recognition of the family as the foundation for the provision of comprehensive services to the child. It is an approach which integrates the child's family into all aspects of health care planning to ensure that the organization and delivery of health care services meet the child's physical, mental, emotional, social and developmental needs. Family-centered care implies that families have alternatives and choices based on their own needs and strengths and should receive support for those choices. It supports the development of trusting and collaborative relationships between providers and family members, and includes sharing of information, as well as joint participation in planning, implementing and evaluating health care programs, policies, services and practices. Building such relationships with families results in better, more efficient care by providing families with education and resources to maximize their child's wellness and the support to care for their children at home whenever possible.

In family-centered health care systems, providers will acknowledge and support the expertise that families bring to their care giving, decision making and care-coordinating roles. Providers will accept and value the richly diverse traditions and languages that families and their children bring to health care settings and will provide families with the information and resources appropriate for the family. In a family-centered system of care, there is recognition that outcomes for children with special health care needs improve when families and providers make decisions jointly, each party respecting the expertise, experiences, training and resources that each brings to the care of the child.

C. Medical Home

For each of the models, the medical home will incorporate the following principles:

1. Each child or youth will have a personal physician;

2. The medical home is a physician directed medical practice;

3. The medical home utilizes a whole child orientation;

4. Care is coordinated and/or integrated across all elements of the health care system and the family and child or youth's community;

5. Quality and safety practices and measures emphasize:

a. The medical home actively advocates for children and youth and their families;

b. Use of evidence-based medicine and clinical decision-support tools to guide decision making;

c. Physicians in the practice accept accountability for continuous quality improvement;

d. Families and children and youth actively participate in decision-making and feedback is sought to ensure patients' expectations are being met;

e. Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication; and

f. Patients and families participate in quality improvement activities at the practice level.

6. The medical home provides enhanced access to care including access to after-hours care; and

7. Payment is structured appropriately to recognize the added value provided to children and youth and their families.

D. Culturally and linguistically appropriate care

Each of the demonstration models and their network of providers will acknowledge and respect the diverse cultural traditions and languages that families bring to health care settings. There will be linguistically and culturally appropriate information and resources available to families.

E. Access to appropriate care

Each of the demonstration models will ensure that there is timely access to the most appropriate care by the most appropriate health care provider. In order to support the multiple and complex needs of children and youth with CCS eligible medical conditions and their families, health care services will be delivered in a coordinated manner to assure that care provided by different sources, regardless of responsibility for reimbursement, is integrated and understood by all involved and that there is no duplication of services.

F. Care Coordination and Case Management

1. Each of the demonstration models will be responsible for focusing on achieving optimal health outcomes for the enrolled child and youth through a combination of care coordination and case management activities. These activities will assist families and children and youth in accessing all necessary health care services that are identified in the course of a child or youth's treatment. It will require an active and in-depth assessment of the child or youth and family, including their strength and abilities as well as their needs; identifying the resources available through the family and larger community; assisting families to access all resources necessary to support the child or youth and family with coping with the illness; and monitoring and follow-up to determine whether the services were received, effective, still needed and whether additional intervention is necessary.

2. The demonstration models through the use of care coordinators will be responsible for proactively responding to the enrolled child or youth and family's needs. This activity will be a team effort that include the child's designated personal physician, the care coordinator, the special care center team (if the child's medical condition requires SCC services), and other professional staff within the contractor's provider's network. It often requires that staff with various levels of expertise spend time assessing the needs of the individual child and determining the appropriate level and site of health care deliver, appropriate and relevant providers of services, arrangements for ancillary care and necessary funding for services and coordination of a multiplicity of services. It often requires close collaboration with a number of other agencies, such as Regional Centers, Special Education, and County Mental Health, to adequately address the complexity of needs of the child or youth and may involve advocacy on behalf of the child or youth and family to obtain the full range of services and support necessary to maximize the child or youth's long range health outcomes.

G. "Whole Child"

Each of the demonstration models, regardless of financial responsibility for specific services, will be held responsible for managing and coordinating the health care of the "whole" child or youth. The contractors will be required to provide the full range of preventive health care services, including periodic health assessments and immunizations, as well as primary health care services that are not related to the care of the CCS eligible medical condition.

H. Quality Monitoring and Quality Improvement Measures

1. Quality monitoring and improvement activities undertaken by each of the contractors will focus on the primary objectives for the program:

   a. Improvement in care coordination;

b. Improvement in access to services and community-based care;

c. Timely provision of primary and preventive care;

d. Increased child/family satisfaction with care;

e. Increased provider satisfaction with the system of care; and

f. Cost-effectiveness of the model.

2. Quality monitoring and improvement will include the following elements:

a. Measures that will quantify improvements in the quality of care received by CCS children and youth, and in order to structure incentive payments tied to achievement of these desired outcomes. Measures will also be included that will evaluate the child or youth and family and/or legal guardian and provider satisfaction and experience with the model. In addition, select disease-specific measures may also be included.

b. Claims data, encounter data and independently generated data (such as data derived from surveys and record review) to comprehensively assess provider performance and to evaluate the effectiveness of the model.

c. Measures related to access to comprehensive and timely care coordination and access to community-based care will be developed with provider and consumer input.

d. Measures related to meaningful outcomes in daily life will be included such as:

1. Self-reported (or family reported) health and/or functional status of child at beginning and end of pilot; and

2. Self-reported (or family reported) school days missed at beginning and end of pilot.

e. Satisfaction with care will be measured and will include the Healthcare Effectiveness Data and Information Set (HEDIS) measure "Satisfaction with Experience of Care: Children with Chronic Conditions".

f. Quality benchmarks for primary and preventive care will focus on standard measures of timeliness of well child checks/adolescent well-care and immunization periodicity. Standard HEDIS measures will be applicable.

g. Claims data analysis will be employed to generate the average PMPM cost for children enrolled in the model compared to those not enrolled, controlling for

factors such as age and diagnosis. Cost analysis will be stratified by age groupings, diagnoses and other relevant criteria.

h. Practice measures might also be employed, such as:

1. Access to after-hours care;

2. Use of an Electronic Health Record (EHR); and

3. Rate of completion of required and evidence-based condition/disease-specific interventions.

III. MODELS OF ORGANIZED DELIVERY SYSTEMS

A. Enhanced Primary Care Case Management

1. Description

The Enhanced Primary Care Case Management (EPCCM) model seeks to achieve many elements of a managed care model utilizing partially capitated financing to implement improvements to the health care delivery system for CCS children and youth. In this model, children and youth choose a personal physician, often called a Primary Care Provider (PCP), who is responsible for functioning, with appropriate administrative support that includes comprehensive care coordination, as an "enhanced medical home" for the recipient.

The medical home provides or ensures the provision of all aspects of care. The personal physician provides primary and preventive care, and in collaboration with the EPCCM administrator, arranges for specialist care and other needed services across the entire continuum of care, settings and funding streams. The medical home also ensures referrals to, and coordination with, existing chronic condition/disease management programs and ensures continuity and coordination of care among multiple providers who are involved in the child's care.

2. Qualified entities

Eligible EPCCM program contractors include county CCS programs, for-profit or non-profit contractors with care and/or disease management expertise, and/or provider-based organizations. To be an eligible EPCCM contractor, an entity must demonstrate the ability to perform the required functions for this model, and meet state defined minimum set of qualifications.

3. Eligible population

   CCS clients eligible for the EPCCM pilot will be those whose CCS eligible medical conditions are anticipated to last at least 12 months. CCS clients with conditions anticipated to last more than 12 months will be required to participate and enroll in the demonstration pilots if they reside in the designated EPCCM pilot service area.

   Neonates who are born with a CCS eligible medical condition that is anticipated to last more than 12 months and meet CCS financial eligibility requirements will be enrolled in the EPCCM at the time eligibility is determined.

   Medical and financial eligibility for the CCS program, as well as enrollment into the pilot, will continue to be determined by the county CCS program.

4. Service areas

   The pilot service area will consist either of a county or a contiguous region of several counties.

5. Provider network

   The EPCCM contractor shall be responsible for the development and maintenance of a comprehensive network of providers to ensure access to and the availability of covered services under the Pilot Project. (**See Section TBD**) The EPCCM will contract with and credential providers based on state requirements, monitor provider access and availability, and provide network support, which would include provider training and education. The contractor Administrator will also be responsible for managing provider grievances and appeals.

6. Scope of services

   See **Section TBD.** The contractor will also be required to provide additional services to fully meet the needs of its members. These services will include, at a minimum, the operation of a 24/7 nurse advice line, operation of member services line, chronic condition/disease management, care coordination, member education and member outreach.

7. System requirements

   a. Outreach and Assessment **(See Section TBD)**

   b. Medical Home and Care Coordination **(See Section TBD)**

8. Reimbursement

The payment model will consist of four main components:

a. Partial Capitation Payment: The EPCCM contractor will receive a monthly capitation payment for outpatient primary, preventive and specialty care services and for coordination of care. The capitation will also include payment for physician services provided during inpatient hospital stays.

b. Monthly Administrative Payment: The EPCCM contractor will receive a monthly capitation payment to support specified administrative functions.

c. Performance-based Payment*:* An annual performance-based payment will be available for the achievement of specific clinical and quality outcomes and process metrics. The contractor will be eligible to receive a portion of the payment with a majority designated as a pass through to the medical home or other direct care providers.

d. Fee-for-Service Payment: Based on the state's fee-for-service schedule, the EPCCM contractor will directly reimburse all other providers for medical services and CCS services provided to enrollees. Specified physician services will continue to be reimbursed at the Medi-Cal rate plus 39.7% percent as is currently required under State regulations.

The EPCCM contractor will be responsible for the authorization of inpatient hospital stays and coordination of services following discharge. Authorized hospital stays will be reimbursed by the Department's Fiscal Intermediary.

B. Accountable Care Organization

1. Description

An accountable care organization (ACO) is defined as a local health care organization and a set of providers (e.g., primary care providers, specialists, hospitals, etc) associated with a defined population of patients, accountable for the quality and cost of care delivered to that population. One of the goal's of this model is to restructure the delivery of health care services to children and youth into an integrated, coordinated and value-based delivery system.

An ACO for the CCS Program will be comprised of a multi-specialty group of physicians and a hospital(s) at which the physicians provider care. Specifically, a CCS ACO will be formed by designated children's hospitals and the physicians within their hospital-based Specialty Care Centers (SCCs) serving children and youth with special health care needs. This model will leverage an already well organized provider-based infrastructure and give providers greater flexibility in,

and accountability for, providing and coordinating medical and supportive services that are cost-effective and appropriate.

The ACO will assume a degree of financial risk at the organization level for its patients. As a comprehensive provider network, the ACO will have a financial interest in achieving cost savings through activities such as enhanced outreach for preventive and primary care, increased use of appropriate outpatient services and accelerated hospital inpatient discharge planning. Performance-based contracting is a primary element of an ACO arrangement and global capitation is typically employed that covers all services needed during a defined period. It may include a condition-specific case rate that is a payment for all care related to a chronic condition, care coordination, primary and preventive care and minor acute episodes associated with a patient's chronic condition.

2. Qualified entities

To be an eligible to be the ACO, an entity must demonstrate the ability to perform the required functions for this model.

3. Eligible population

The target population for the ACO model will include a subset of the CCS population with a chronic eligible medical condition (anticipated to last 12 months or more) whose needs are best met by hospital-based outpatient SCCs. This population *may* include children or youth who have been identified as having one of the following specified conditions:

a. Malignancies (specifically leukemia, brain tumors, lymphomas);

b. Sickle cell disease;

c. Cystic fibrosis;

d. Cardiac conditions, including disorders of the myocardium and heart valves and congenital heart disease ; and

e. Spina bifida.

Children and youth residing in the designated geographic service area and eligible for the ACO and receiving Medi-Cal services under fee-for-service will be automatically enrolled into the ACO. Children and youth enrolled in Medi-Cal or Healthy Families managed care plans, if the managed care plans are operating in the pilot service area, will be notified of pending disenrollment from the Medi-Cal or Healthy Family managed care plan and enrollment into the ACO. All CCS-only children and youth meeting the medical eligibility criteria for the ACO will also be assigned to the ACO.

Neonates who are born with a CCS eligible medical condition eligible for the ACO model and who meet CCS financial eligibility requirements will be enrolled in the ACO at the time eligibility is determined.

4. Service areas

   The pilot service area may be the counties in which the provider organizations are located; or there will be no defined geographic service area, with the designated provider organizations continuing to provide care to and enroll children or youth that have historically received care at the organization regardless of county of residence.

5. Provider network

   The ACO shall be responsible for the development and maintenance of a comprehensive network of providers to ensure access to and the availability of covered services under the Pilot Project. (**See Section TBD**) The ACO will contract with and credential providers based on state requirements, monitor provider access and availability, and provide network support, which would include provider training and education. The contractor will also be responsible for managing provider grievances and appeals.

6. Scope of services

   See **Section TBD.** The ACO will also be required to provide additional services to fully meet the needs of its members. These services will include, at a minimum, the operation of a 24/7 nurse advice line, operation of member services line, chronic condition/disease management, care coordination, member education and member outreach.

   Under the proposed reimbursement structure, the ACO has the flexibility to provide non-covered (supplemental) services at its discretion.

7. System requirements

   a. Outreach and Assessment **(See Section TBD)**

   b. Medical Home and Care Coordination **(See Section TBD)**

8. Reimbursement

   Under the ACO model, the Department will provide a pre-paid monthly global payment for each child enrolled in the ACO program. This global payment will be based on the services that will be the responsibility of the ACO, which will include

all services required for the treatment of the child's CCS condition(s), care coordination and, at a minimum, preventive and primary care services such as well-child checks and immunizations.

The methodology for the global payment will use one or more of the following: risk-adjusted rates, risk-corridors, and/or stop-loss mechanisms to protect the ACO from significant financial risk, particularly in the first few years of the model. Additionally, a performance-based incentive payment for the achievement of specific cost, clinical and quality outcomes and metrics may be developed.

One area of likely cost-savings will result from the ability of the ACO to increase use of community-based care; thus, reducing inpatient hospital days. At present, there is a "perverse incentive" associated with inpatient care. The ACO will have an incentive to improve access to home-based care, an option that is also highly desired by families as well as improved care transitions for children being discharged from the hospital.

The ACO will be responsible for authorization and payment to ACO member-providers for services under the global payment. The ACO will establish contracts with providers to establish billing and payment provisions for the services included in the global payment.

C. Specialty Health Care Plan

1. Description

The State will pilot a specialty health care plan that is solely focused on children and youth with special health care needs with medical conditions eligible under the CCS program that are anticipated to last 12 months or more. Under this model, the State will contract with specialty health care plan(s) that will be responsible for managing all of the child's health care needs across the entire continuum of care and services, not just care for their CCS condition. In counties with Medi-Cal managed care, if CCS clients are enrolled in a plan, they would be disenrolled from the Medi-Cal managed care plan and enrolled into the specialty health care plan.

The DHCS will establish contract performance standards and measures that are tailored to the CCS population and are measurable and enforceable. Requirements will be included for tailored clinical programs, specialized provider networks and family-centered care management strategies to meet the unique and distinct needs of CCS children.

The administrative responsibilities for operations of the program will be divided among the state, county and specialty health care plan.

2. Qualified entities

   A specialty health care plan must be Knox Keene licensed and demonstrate the ability to perform the required functions for this model as defined in this document.

3. Eligible population

   CCS clients eligible for the Specialty Health Care Plan will be those whose CCS conditions are anticipated to last at least 12 months. Neonates who are born with a CCS eligible medical condition that is anticipated to last more than 12 months and meet CCS financial eligibility requirements will be enrolled in the specialty health care plan at the time eligibility is determined.

   All eligible CCS children and youth residing in the designated geographic service will be required to participate in the demonstration pilot.

   Medical and financial eligibility for the CCS program, as well as enrollment into the pilot, will continue to be determined by the county CCS program.

4. Service areas

   The pilot service area will consist either of a county or a contiguous region of several counties.

5. Provider network

   The Specialty Health Care Plan shall be responsible for the development and maintenance of a comprehensive network of providers to ensure access to and the availability of covered services under the Pilot Project. (**See Section TBD**) The Contractor will contract with and credential providers based on state requirements, monitor provider access and availability, and provide network support, which would include provider training and education. The contractor will also be responsible for managing provider grievances and appeals.

6. Scope of services

   See **Section TBD.** The plan will also be required to provide additional services to fully meet the needs of its members. These services will include, at a minimum, the operation of a 24/7 nurse advice line, operation of member services line, chronic condition/disease management, care coordination, member education and member outreach.

   The specialty health plan has the flexibility to provide non-covered (supplemental) services at its discretion.

7. System requirements

a. Outreach and Assessment **(See Section TBD)**

b. Medical Home and Care Coordination (**See Section TBD)**

8. Reimbursement

The Specialty Health Plan will be paid on a capitated basis (a per member per month payment) and may be fully at-risk or partially at-risk. Those that serve high-cost members require a risk-adjusted capitation payment that is commensurate with the risk of the enrollees served by the plan. Due to the anticipated small enrollment in the specialty health plan, it is anticipated the financing arrangements will include risk-corridors or other stop-loss mechanisms, particularly in the first few years of the program.

The risk-based rates will be developed in a way that serves as an incentive for certain desired outcomes including the elements of a fully functional medical home, such as:

a. Reduced inpatient care in favor of outpatient and home-based care;

b. Enhanced care coordination;

c. Implementation of disease/chronic condition management practices; and/or

d. Implementation of electronic medical records, e-prescribing and other technologies demonstrated effective in improving outcomes and reducing costs.

Under a capitated payment structure, a specialty health plan has the flexibility to substitute services and/or provide enhanced services based upon the individual needs of the child that may extend beyond the current covered services.

D. Medi-Cal Managed Care Plan

1. Description

Under this model DHCS will pilot the inclusion of children and youth with special health care needs that are eligible under the State's CCS program into one or more existing Medi-Cal managed care plans to provide enhanced continuity of care, better align incentives and optimize health outcomes . Under this model, the participating plans will be responsible for managing all of the child or youth's health care needs across the entire continuum of care and services, including services to treat the CCS eligible medical condition.

The State will amend its current contracts with participating Medi-Cal managed care plan(s) to include financial responsibility for the provision of services to treat the CCS eligible medical condition. Through a contract amendment process, DHCS will also establish new Medi-Cal managed care contract performance standards and measures for the participating plan(s)that are tailored to the CCS population and are measurable and enforceable.

These requirements will include specialized provider networks, family-centered care management and care coordination strategies to meet the unique and distinct needs of CCS children and youth.

With the exception of CCS program eligibility determination, program reporting and quality oversight which will remain the responsibility of the county and the state, most administrative functions of the CCS program would become the responsibility of the participating Medi-Cal managed care plan(s).

2. Qualified entities

   An entity must demonstrate the ability to perform the required administrative functions for this model and have an existing contract with DHCS under the Medi-Cal Managed Care program.

3. Eligible population

   All children and youth with CCS eligible medical conditions residing in the designated geographic service area, regardless of source of funding for their services and how long the conditions are expected to last, will be enrolled into the Medi-Cal Managed Care Plan.

   Medical and financial eligibility determination for the CCS program will continue to be performed by the county CCS program in order to ensure that the Plans are appropriately identifying CCS children.

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4. Service area

   The pilot service area will be one county for each participating plan and include eligible children and youth residing in the county.

5. Provider network

   The contractor shall be responsible for the development and maintenance of a comprehensive network of providers to ensure access to and the availability of covered services under the Pilot Project. (**See Section TBD**) The Contractor will contract with and credential providers based on state requirements, monitor provider access and availability, and provide network support, which would

include provider training and education. The contractor will also be responsible for managing provider grievances and appeals.

6. Scope of services

   See **Section TBD.** The plan will also be required to provide additional services to fully meet the needs of its members. These services will include, at a minimum, the operation of a 24/7 nurse advice line, operation of member services line, chronic condition/disease management, care coordination, member education and member outreach. The managed care plan has the flexibility to provide non-covered (supplemental) services at its discretion.

7. System requirements

   a. Outreach Activities **(See Section TBD)**

   b. Medical Home and Care Coordination **(See Section TBD)**

8. Reimbursement

   The Medi-Cal Managed Care plan will be reimbursed by the Department on a capitated basis (a per member per month payment) for a defined set of covered benefits and services. The health plans will be fully at-risk for the provision of all covered services, including CCS covered benefits and services. An actuarially sound capitation payment will be developed to reflect the inclusion of CCS covered benefits and services under the Medi-Cal managed care pilot.

   There will be development of risk-adjusted rates for the CCS-eligible population.. Additional strategies such as reimbursement for care coordination services and re-insurance; stop loss; risk corridors, and risk-sharing arrangement may not be necessary in this pilot.

   Under a capitated payment structure, health plans have the flexibility to substitute services and/or provide enhanced services based upon the individual needs of the child that may extend beyond the current covered services.

IV. CORE REQUIREMENTS OF ALL DEMONSTRATION MODELS

A. Family-Centered Care

1. Parental Involvement

   Each contractor shall ensure that delivery of medically necessary health care is done in ways that support the development of trusting relationships between providers and family members. Consideration must be given to factors such as promoting continuity of providers and allowing adequate time at visits to

encourage provider-family dialogue and the management of care coordination issues.

The contractor shall ensure that the following core elements of family-centered care are integrated into provider practices.

a. **Respect and dignity.** Health care practitioners listen to and honor patient and family perspectives and choices.

b. **Information Sharing.** Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.

c. **Participation.** Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.

d. **Collaboration.** Health care professionals collaborate with patients and families at all levels of health care, including: care of an individual child; program development, implementation and evaluation; and policy formation.

2. Transition planning

Each contractor will ensure that all enrolled youth, with a medical condition expected to last beyond the 21st birthday, receive the services necessary to make transitions to adult health care. It will be necessary to work with enrolled youth and their families to prepare them for how their future health care needs will be met once eligibility for the CCS program ceases at the 21st birthday.

Each contractor will ensure that enrolled youth will have a transition plan done on an annual basis beginning at 14 years of age, prepared in conjunction with the youth and family.

Each contractor will work with the family of enrolled youth to ensure that families have considered whether to apply for conservatorship for the enrolled youth prior to the 18th birthday.

B. Service Network and Access to Care

1. General

The contractor shall ensure appropriate, timely access of enrolled children and youth to CCS approved providers with the necessary expertise to provide comprehensive care, including the prevention, diagnosis and treatment of the full range of medical conditions experienced by children and youth with CCS eligible

medical conditions. The contractor will implement and maintain procedures to ensure that enrolled children and youth have access to routine primary care, periodic health assessments, urgent care, specialist care, inpatient care, emergency care and minor consent and sensitive services for adolescents.

a. Preventive Care

The contractor will maintain and operate a system of care which ensures the provision of preventive care including, but not limited to, immunizations, growth and development assessments, appropriate health screening, health care supervision and patient and parental counseling about health and psychosocial issues.

b. Primary Care

The contractor shall provide access to health care services 24 hours a day, seven days a week, through a system which includes direct access ot the enrolled child's identified primary physician or the physician's designee, who shall provide medical triage and management of the identified problems, including appropriate and timely referral for care. Recorded messages are unacceptable for this purpose.

c. Specialty Care

1) The contractor shall maintain adequate numbers and types of CCS approved providers to ensure that all medically necessary specialty services are made available to enrolled children and youth in a timely manner.

2) The contractor shall ensure that enrolled children and youth are referred to the appropriate CCS approved Special Care Center for medical management and coordination of multispecialty, multidisciplinary coordinated care when the child or youth has a CCS eligible medical condition that include, but are not limited to:

a) Congenital heart disease
b) Cardiac conditions, such as cardiac myopathies or valvular disorders
c) Metabolic disorders
d) Chronic renal disease
e) Cystic fibrosis and chronic pulmonary disease
f) Malignant neoplasms
g) Hemophilia
h) Hemoglobinopathies
i) Craniofacial anomalies, including cleft palates
j) Endocrine disorders, including diabetes

k) HIV disease, or other acquired and/or congenital immune deficiency disease
l) Gastrointestinal conditions with complex medical/nutritional requirements
m) Sensorineural hearing loss
n) Limb defects and other disorders requiring intensive rehabilitation
o) Meningomyelocele
p) Rheumatic and connective tissue disorders
q) Infants discharged from a CCS approved NICU at risk for developing a developmental disability and meeting the eligibility criteria for the CCS HRIF program

d. Emergency and After Hours Care

1) The contractor will maintain a system able to provide:

a) 24 hour, seven day per week, telephone access for families of children in the Pilot Project to personnel qualified to provide advice and triage access to emergency services

b) 24 hour, seven day per week, telephone access by providers to obtain service authorization for medically necessary, non-emergency care

2) The contractor will maintain (directly or through sub-contract and/or referral) sufficient numbers of inpatient hospital, service sites and qualified personnel to ensure provision of all medical care necessary under emergency circumstances.

3) An appropriately qualified health care professional working under the supervision of the Pilot Project's Medical Director shall be available 24 hours a day and responsible for the timely authorization of medically necessary emergency care. The health care professional, working with the Medical Director, shall coordinate the transfer of stabilized children form emergency departments (including those in the provider network and no-contractor emergency departments) and admission to the appropriate facility for inpatient care, as necessary.

4) The contractor shall develop and maintain protocols for communicating and interacting with emergency departments in the designated geographic service area, which will include, at a minimum:

a) Procedures for emergency departments to report system and/or protocol failures and the process for ensuring corrective action.

b) Referral procedures (including after-hours instruction) which emergency department personnel can provide to families of enrolled

children who present at the emergency department for non-emergency services.

e. Appointment Availability/Waiting Time

1) The contractor must adhere to the following time frames in implementing the system of care.

2) All non-symptomatic office visits, e.g, routine wellness/preventive care appointments, periodic visits for medication or management review, shall be available to the child/family within forty-five (45) calendar days of request.

3) Symptomatic office visits which are non-emergent in nature shall be available within twenty-four (24) hours of request. Such visits might include care for symptoms or diagnoses which may or may not be related to the treatment of the CCS eligible medical condition, such as an upper respiratory infection in a child with moderately severe asthma, ear pain in a child with cleft lip and palate.

4) Urgent Care appointments for conditions such as recurring high fever, moderate to severe nonspecific pain, hematuria or dyspnea, shall be available on a same day basis.

5) Emergency services shall be available seven days a week, 24-hours per day within 30 minutes travel time from the child's home. Emergency services shall not be subject to prior authorization by the Pilot Project.

2. Provider Network

The contractor shall maintain a network of CCS approved health care providers and health care facilities. The network shall provide the full scope of benefits required of children enrolled in the Pilot Project and shall ensure access to these providers. The network of providers shall include:

a. Primary Care Physicians

Primary care physicians including CCS approved pediatricians and family physicians and, for children age 14 and older, CCS approved internists.

b. Pediatric Medical Specialties and Subspecialties

CCS approved physicians in the following pediatric medical specialties and subspecialties: adolescent medicine, behavioral/developmental pediatrics, cardiology, critical care medicine, dermatology, endocrinology, hematology-oncology, infectious disease, neonatology, nephrology, neurology,

neurodevelopmental pediatrics, physical medicine and rehabilitation, psychiatry, pulmonology and rheumatology.

c. Pediatric Surgical Specialties and Subspecialties

CCS approved physicians in the following pediatric surgical specialties and subspecialties; cardiac surgery, otolaryngology, pediatric surgery, and urology.

d. Other Physician Providers

CCS approved physicians specializing in allergy and immunology, neurosurgery, obstetrics and gynecology, ophthalmology, oral and maxillofacial surgery, orthopedics, otolaryngology, plastic surgery, thoracic surgery, and urology

e. Other Health Care Professionals

Other health professionals with experience in treating children with CCS eligible medical conditions and their families, including CCS approved genetic counselors, marriage and family therapists, occupational therapists, physical therapists, speech and language pathologists, audiologists, dietitians, registered nurses, psychologists and medical social workers/licensed clinical social workers.

f. Hospital Facilities

CCS approved inpatient hospital facilities that are capable of providing a full range of medically necessary hospital care appropriate to an enrolled child's CCS eligible medical conditions. The facilities must include CCS approved tertiary hospitals in the Pilot Project's geographic service area.

g. Inpatient Special Care Centers (SCCs)

CCS approved inpatient SCCs including Neonatal Intensive Care Units (NICU), Pediatric Intensive Care Units (PICU) and Pediatric Rehabilitation Centers. The NICUs must include, at a minimum, CCS approved Regional NICUs in the Pilot Project's geographic service area.

h. Outpatient Special Care Centers

CCS approved outpatient SCCs including:

1) Amputee Centers
2) Bone Marrow Transplant Centers
3) Burn Centers

4) Cardiac Centers
5) Communication Disorder Centers, Type C
6) Craniofacial Centers
7) Cystic Fibrosis and Pulmonary Disease Centers
8) Gastrointestinal Centers
9) Heart and Lung Transplant Centers
10) Heart Transplant Centers
11) Hematology/Oncology Centers
12) Hemophilia Centers
13) High Risk Infant Follow-up Centers
14) Immunology/Infectious Disease Centers
15) Liver Transplant Centers
16) Metabolic (including PKU) and Endocrine Centers
17) Prosthetic/Orthotic Centers
18) Renal Dialysis and Transplant Centers
19) Rheumatology Disease Centers
20) Selective Posterior Rhizotomy Centers
21) Sickle Cell Disease Centers
22) Specified Inherited Neurological Diseases Centers
23) Spina Bifida Centers

i. Other healthcare providers

Licensed pharmacies, hearing aid dispensers, home health agencies, durable medical equipment vendors, prosthetists, orthotists, clinical diagnostic laboratories, medical supply vendors, medical imaging (radiology, ultrasound, magnetic resonance imaging),

3. Specific Requirements (Medical Professionals)

a. Physician Credentialing

The contractor will develop and maintain written policies and procedures for credentialing, re-credentialing, recertification and reappointment of practitioners. The initial credential process for physicians will include verification of the following information:

1) Current valid licensed to practice in the State of California by the Medical Board of California or the Board of Osteopathic Medicine.

2) Current Drug Enforcement Agency registration.

3) Graduation from medical school, completion of a residency, Board certification or Board eligible, as applicable.

4) Clinical privileges in good standing at a CCS approved hospital, including a review of past history of curtailment or suspension of medical staff privileges.

5) Enrollment as a CHDP provider if serving as a primary physician with the intent to provide primary and preventive health care services.

6) Work history.

7) Current, adequate professional liability coverage and claims history.

8) Information from the National Practitioner Data Bank.

9) Enrollment as a Medi-Cal provider and history of any sanctions imposed by Medi-Cal, Medicaid or Medicare.

10) Sanctions or limitations on licensure from State agencies or licensing boards.

11) A signed statement by the practitioner at time of application regarding any physical or mental health problems, any history of chemical dependency/substance abuse, history of loss of license and/or felony convictions, history of loss or limitation of privileges or disciplinary actions.

b. Re-credentialing

1) Each contractor must ensure that network physicians are credentialed every three years. The process must include re-verification of:

a) Licensure
b) Board certification
c) Admitting privileges at a CCS approved hospital
d) Malpractice insurance
e) Valid DEA Certificate
f) National Practitioner Data Bank Information
g) Medi-Cal, Medicaid or Medicare sanctions; and Sanctions or limitations on licensure from State agencies and licensing boards.

2) The process must include a singed and dated application that includes an attestation as to the correctness and completeness of the information.

3) Re-credentialing must also include documentation that the contractor has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, member complaints and medical records reviews.

c. Primary Physician

1) Each enrolled child or youth shall be assigned a network primary physician during the enrollment process. The primary physician may be either a primary care physician, a pediatric medical specialist or subspecialist appropriate to the child's CCS eligible medical condition.

2) The primary physician will assume the responsibility for directly overseeing all aspects of the child or youth's health care. The latter includes primary care, preventive services, assessment, diagnosis and treatment of illness and conditions unrelated to the treatment of the CCS eligible medical condition; determining the medical services necessary to correct, treat and/or ameliorate the child or youth's CCS eligible medical condition, working with the family to develop the care plan; working with the assigned care coordinator to assure appropriate referral and arranging access to pediatric specialists and subspecialists and other services as needed; and participating in all aspects of the case management system including multidisciplinary care conferences.

d. Provider Education and Quality Assurance

The contractor will be responsible for assuring that assigned primary physicians have received the training necessary to fulfill their roles and responsibilities. Specifically, the contractor shall have written policies and procedures pertaining as to how the provider network will be informed/educated regarding the Pilot Project's requirements, and how compliance with the stated standards will be monitored and an effective action plan implemented if the standards are not met.

4. Access Requirements

a. Telephone Access and Response Time

The contractor shall implement a system which ensures toll-free telephone access to provide information regarding clinical services, to respond timely to concerns and to answer questions pertaining to member services.

1) Requests for medical advice

The contractor will develop and maintain a specific toll-free telephone number and procedure for triaging calls from families of enrolled children and youth and providing telephone medical advice. The telephone line will be staff on a 24 hour/7 day per week basis by a licensed Registered Nurse with pediatric experience and training provided by the contractor.

2) Services Information

The contractor shall establish a specific toll-free member services telephone number to assist with questions that families of enrolled children and youth may have about the Pilot Project's providers and benefits.

b. Geographic/Physical Access

1) Travel Time

The contractor shall ensure that its provider network includes primary physicians who are located within thirty (30) minutes or ten (10) miles of an enrolled child's residence unless the Pilot Project has a DHCS approved alternative time and distance standard.

To the extent possible, the contractor must maintain a network of providers with specific training and expertise in care for children with CCS eligible medical conditions, including pediatric specialists in, or close to, the community in which enrolled children live. A child or youth or the child's family may elect to travel further, but should have the opportunity to receive services in their home community whenever possible.

Coordination and collaboration among the contractor and local community resources shall be developed to ensure that existing appropriate health car delivery systems and supportive services are utilized and that enrolled children are not unnecessarily required to change from their usual provider.

2) Physical Accessibility

Primary care facilities must be physically accessible as required by federal and state laws, and shall have accessible waiting rooms, hallways, examining rooms, rest rooms and examining tables.

c. Linguistic and Cultural Access

The contractor shall ensure that communication and/or cultural barriers will not inhibit enrolled children and youth and their families from obtaining services from the health care system.

1) Linguistic Access, Communication Issues

a) Communication impairments

The contractor shall establish methods for communicating effectively with children and youth and their families who have a range of

communication-affecting conditions, including cognitive, vision or hearing impairments, to ensure that enrolled children and youth and their families can make informed decisions.

Standard informational and/or education materials shall be made available to enrolled children and youth and their families in alternative formats, e.g., written, Braille, audio/video tape, etc. Sign language interpretation for English speaking hearing impaired individuals shall also be available upon request.

b) Non-English Speaking Enrolled Children and Families

Interpreter services shall be made available for planned encounters with children or youth or families with limited proficiency in comprehending English to ensure that enrolled children and their families are afforded full access to Pilot Project services and benefits. In addition, interpretation services shall be made available on an ad hoc basis for unplanned or emergency contacts.

These services shall include the ability to orally translate commonly used medical terminology from English to languages used by enrolled children and youth and their families and form the child or youth's or family's language to the English language.

Written materials, including commonly used forms and informational materials, shall be available in languages appropriate to the enrolled population. Sign language interpretation for non-English speaking hearing impaired individuals shall be made available upon request.

2) Linguistic Services

Contractor shall comply with Title 22, CCR, Section 53853(c) and ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal beneficiaries receive 24-hour oral interpreter services at all key points of contact, either through interpreters or telephone language services.

Contractor shall provide, at minimum, the following linguistic services at no cost to Medi-Cal members:

a) Oral Interpreters, signers, or bilingual providers and provider staff at all key points of contact. These services shall be provided in all languages spoken by Medi-Cal beneficiaries and not limited to those that speak the threshold concentration standards languages.

b) Fully translated written informing materials, including but not limited to the Member Services Guide, enrollee information, welcome packets, marketing information, and form letters including notice of action letters and grievance acknowledgement and resolution letters. Contractor shall provide translated written informing materials to all monolingual or LEP members that speak the identified threshold or concentration standard languages. The threshold or concentration languages are identified by DHS within the contractor's service area. DHS will notify Contractor of the threshold or concentration languages in Contractor's service area.

c) Referrals to culturally and linguistically appropriate community service programs.

d) Telecommunications Device for the Deaf (TDD)

3) Access to Culturally Appropriate Care

The contractor shall provide a mechanism to ensure that health care services provided through the Pilot Project are designed and delivered in a manner which is sensitive and responsive to the varying cultural needs of the enrolled children and youth and their families.

This mechanism shall, at a minimum, address:

a) Staffing that reflects the racial and ethnic makeup of the population served, and is familiar with the cultural backgrounds of enrolled children and youth.

b) Written polices stating the importance of culturally competent care and acknowledging differing cultural definitions of "family" and respecting differing views of medical care.

c) Provision for asking each family who should attend conferences, what kind of translation services are needed, what are the families' concerns and what added assistance is needed to gain access to care.

d) Provision for working with families and providers when the child or youth's and/or family's view of the illness and treatment differs substantially from the physician's.

e) Protocols for defining and removing practices which are found to be barriers to care for enrolled children and youth.

C. Scope of Services

1. General

   Each of the demonstration models shall provide or arrange for all Medically Necessary Covered Services for children and youth enrolled in the Pilot Project. Covered Services are those services set forth in Title 22, CCR, Chapter 3, Article 4, beginning with Section 51301, and Title 17, CCR, Division 1, Chapter 4, Subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of this Contract.

   These services must include all medically necessary primary and preventive health care services, diagnostic assessments, treatment, rehabilitation and follow-up care in addition to the care coordination and case management that are necessary for the appropriate treatment of the CCS eligible condition.

2. Medically Necessary Services

   "Medically necessary" services are all covered services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury. (Title 22, CCR, Section 51303[a]) or are services necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by a health care practitioner operating within the scope of his or her practice as long as the services are medical in nature and are not requested solely for the convenience of the beneficiary, family, physician or another provider of services (Title 22, CCR, Section 51340[e][3][A]).

3. Covered Services

   Each of the demonstration models shall provide the following services for CCS clients enrolled in a pilot:

   a. Physician Services

      1) Preventive Services

      2) Periodic Health Assessments

         The contractor shall provide preventive health visits for all enrollees at the times specified by the most recent AAP periodicity schedule. As part of the periodic preventive visit, all age specific assessments and services required by the CHDP program and the age specific health education and behavioral assessment will be provided as necessary.

      3) Immunizations

The contractor shall cover and ensure the timely provision of vaccines in accordance with the most recent childhood immunization schedule and recommendations published by the Advisory Committee on Immunization Practices (ACIP).

Upon federal Food and Drug Administration (FDA) approval of any vaccine for childhood immunization purposes, the contractor shall develop policies and procedures for the provision and administration of the vaccine. Such policies and procedures shall be developed within thirty (30) calendar days of the vaccine's approval date. The contractor shall cover and ensure the provision of the vaccine from the date of its approval regardless of whether or not the vaccine has been incorporated into the Vaccines for Children (VFC) Program. Policies and procedures must be in accordance with any Medi-Cal Fee-For-Service guidelines issued prior to final ACIP recommendations.

The contractor shall provide information to all network providers regarding the VFC Program.

4) Blood Lead Screens

The contractor shall cover and ensure the provision of a blood lead screening test to enrollees at ages one (1) and two (2) in accordance with Title 17, Division 1, Chapter 9, Articles 1 and 2, commencing with Section 37000. The contractor shall document and appropriately follow up on blood lead screening test results.

5) Primary Care Services

The contractor shall cover all primary care services for enrolled children.

6) Pediatric Specialist Services

7) Laboratory and Radiology Services

b. Inpatient/Outpatient Hospital Services

c. Special Care Center (SCC) Services

SCC services shall be provided for those children whose medical condition and/or complicating conditions require referral to and treatment by a CCS approved SCC.

1) SCC services are coordinated multidisciplinary, multispecialty team approaches to the assessment and management of children with chronic,

complex medical conditions. A center's core team includes a medical director (a specialist in treatment of medical conditions seen at the center), a nurse specialist and a social worker. A team frequently also includes the consultation of a dietitian, as well as other appropriate pediatric medical and surgical specialists and subspecialists.

2) The services provided by the centers include:

a) Initial and periodic comprehensive outpatient evaluations by health care professionals on the center team.

b) Diagnostic services when there is a need to establish the presence of a CCS eligible condition or the status of an eligible condition.

c) Treatment services provided or requested by CCS approved physician team members to manage a child's CCS eligible condition.

d) Initial and periodic team conferences to coordinate decision making and health care services identified by team members as needed by the child.

e) Periodic reports to the CCS program on status of child and treatment recommendations.

f) Group teaching.

g) Outpatient laboratory and/or radiology services as order by the CCS approved physician team members.

d. Emergency Services

e. Services Provided in the Home and Community

1) Home health services

a) Intermittent services by a Home Health Agency

i. Skilled nursing services by licensed nursing personnel
ii. Physical therapy
iii. Occupational therapy
iv. Speech therapy
v. Home health aide
vi. Respiratory care therapy

b) Shift nursing services

2) Hospice

3) DME

a) Rehabilitative

The contractor will provide standard and custom durable medical equipment required for mobility, community access and independence in the home environment. This equipment may include, but is not limited to, tilt wheelchairs, power chairs, walkers, commodes, positioning equipment, custom wheel chairs, custom wheel chair seating, custom motorized wheelchair bases and batteries. All repairs, replacements due to growth and/or new technology, maintenance, family training and follow up on the use of the equipment are also the responsibility of the contractor.

b) Medical

The contractor will provide medical, including respiratory equipment required for the treatment of the enrolled child or youth's medical conditions in the home. Such equipment may include, but is not limited to apnea monitors, glucometers, infusion pumps, kangaroo pumps, ventilators, suction machines, gaseous and/or liquid oxygen, specialty beds and mattresses.

The contractor will provide emergency back up equipment, maintenance of the equipment and family training in the use of the equipment.

4) Medical Supplies

The contractor will provide those supplies that are necessary for treatment of medical conditions within the home and community, including those supplies that are necessary for the administration of prescribed pharmaceuticals. These supplies shall include, but are not limited to, gauze pads, syringes, infusion sets and catheters.

5) Incontinence supplies

The contractor will provide diapers when

a) A child is under five years of age and the use of diapers is medically necessary and exceed the normal use by a child of the same age; or

b) A child is five years of age and older and the diapers are medically necessary.

6) Prosthetics and orthotics

The contractor will provider prosthetics (devices utilized to replace or enhance a body part of function) and orthotics (devices to correct or prevent deformities, replace a body function and/or for positioning). These items shall include, but are not limited to, dynamic splints, shoes, braces, artificial arms and legs.

The contractor will be required to provide orthotics repairs, adjustments and/or replacements necessary for growth or new technology; usage training, as well as routine clinical check ups by appropriate clinicians.

f. Medical transportation

The contractor will be responsible for the provision of emergency transportation by ground ambulance when it is needed to access medically necessary care in emergency situation.

The contractor will also provide emergency transportation by air ambulance when the enrolled child or youth's condition requires rapid transport, when it is a reasonable alternative to ground transport or when air transport is less costly.

The contractor will provide nonemergency transport by ambulance or wheelchair van and litter van when there is documentation that the child's medical condition warrants the use of one of these types of transport rather than private care or public transportation. This method of transportation will also be provided when an enrolled child or youth is to be transferred from a tertiary care facility for inpatient care in a lower level facility in his/her own community or nearer to his/her community.

g. Maintenance and transportation to access authorized services

The contractor shall be responsible for reimbursing the costs of the family of an enrolled child or youth in accessing authorized health care services when it is determined there are no other available resources.

Reimbursable services shall include:

1) The cost(s) for the use of a private vehicle or public conveyance to provide the enrolled child or youth access to authorized care that is part of the treatment plan.

2) The cost(s) for lodging (such as a motel room, etc.) and food for the child or youth or family when needed to enable the child or youth to access CCS authorized medical services.

h. High Risk Follow-up Services, as provided by the HRIF SCCs

1) Comprehensive history and physical exam
2) Developmental assessment
3) Family psychosocial assessment
4) Hearing assessment
5) Ophthamological assessment
6) Home assessment

i. Pharmacy services

1) The contractor shall be responsible for the provision of all prescribed drugs and medically necessary services that shall include:

a) Licensed pharmaceuticals
b) Investigational drugs
c) Unlabeled use of drugs
d) Over-the-counter medications
e) Medical foods
f) Enteral/parenteral nutrition

2) Pharmaceutical services and prescription drugs shall be provided in in accordance with all Federal and State laws and regulations including, but not limited to the California State Board of Pharmacy Laws and Regulations, Title 22, CCR, Section 56214 and Title 16, Sections 1707.1, 1707.2, and 1707.3. Prior authorization requirements for pharmacy services and provision of prescribed drugs must be clearly described in the Member Services Guide and provider manuals.

3) At a minimum, the contractor shall arrange for pharmaceutical services to be available during regular business hours, and shall ensure the provision of drugs prescribed in emergency circumstances in amounts sufficient to last until the child or youth or family can reasonably be expected to have the prescription filled.

4) Contractor shall develop and implement effective drug utilization reviews and treatment outcomes systems to optimize the quality of pharmacy services.

j. Minor consent and sensitive services

Contractor shall ensure the provision of Minor Consent Services for individuals under the age of eighteen (18). Minor Consent Services shall be available within the provider network and members shall be informed of the availability of these services. Minor consent services are services related to:

1) Sexual assault, including rape.

2) Drug or alcohol abuse for children twelve (12) years of age or older.

3) Pregnancy.

4) Family planning

5) Sexually transmitted diseases (STDs), designated by the Director, in children twelve (12) years of age or older.

6) Outpatient mental health care for children twelve (12) years of age or older who are mature enough to participate intelligently and where either (1) there is a danger of serious physical or mental harm to the minor or others, or (2) the children are the alleged victims of incest or child abuse.

7) Minors do not need parental consent to access these services.

k. Family planning services

Enrollees, 12 years of age and older, shall be able to access Family Planning Services in a timely manner, through an out-of-network provider other than the primary physician if so requested with mechanisms in place for reimbursing such services.

l. Organ Transplants

1) Heart, Lung, Heart/Lung, Liver, Small Bowel or Bone Marrow Transplant

a) The contractor must refer all enrolled children and youth thought to require heart, lung heart/lung, liver, small bowel or bone marrow transplants to a Medi-Cal approved organ transplant center for the comprehensive evaluation of the need for the transplant. The contractor will be responsible for the costs of the evaluation.

b) The contractor will also be responsible for:

Assuring that enrolled children and youth identified by a Medi-Cal approved transplant center as needing a transplant are referred to the

CMS Branch for review and determination of medical eligibility for transplant and then for authorization.

Coordinate pre- and post-transplant services; and Assist the family with necessary support services during the entire process.

2) Renal and Corneal Transplants

The contractor will be responsible for all costs and care associated with the provision of renal and corneal transplants.

a) Enrolled children and youth requiring renal transplants will be referred to a CCS approved renal center for evaluation of the need for and the care of the transplant.

b) Enrolled children and youth requiring corneal transplants will have that care provided under the direction of a CCS approved ophthalmologist.

m. Dialysis

n. Therapies

1) Speech and language

2) Physical and occupational therapy

The contractor shall provide physical and occupational therapy when:

a) Short-term physical and/or occupational therapy, defined time-limited goals, is necessary to improve functional skills, eliminate the need for extension of an inpatient hospital stay and/or to prevent re-hospitalization; or

b) Long-term physical and/or occupational therapy, with time-limited goals, is necessary to maintain or prevent deterioration of functional skills.

3) The contractor shall not be responsible for the provision of physical and occupational therapy services prescribed by a CCS Medical Therapy Conference physician.

o. Augmentative and alternative communication devices

1) The contractor will be responsible for providing electronic or non-electronic aids, devices, or systems (in a form most appropriate for the enrolled child or youth) that correct an expressive communication disability that

precludes effective communication and precludes meaningful participation in daily activities.

2) The contractor will be responsible for the assessment by a CCS approved speech/language pathologist, in conjunction with either an occupational or physical therapist, to determine the necessity and appropriateness of a device.

3) The contractor will also be responsible for the provision of the necessary components, including computer software programs, symbol sets, overlays, mounting devices, switches, cables, connectors and output devices, supplies, training in the use of the device and device repair and modification.

p. Audiology

1) Diagnostic and ongoing assessment by CCS approved Communication Disorder Centers (CDC), including CCS approved otolaryngologists, audiologists and speech and language therapists.

2) If a candidate for amplification, then the contractor is also responsible for:

a) Hearing aids, as recommended by a CCS approved CDC, prescribed for an enrolled child or youth's hearing loss, including those that are beyond the scope of Medi-Cal benefits.

b) Hearing aid accessories, including cords, receivers, ear molds and batteries

c) Assistive listening systems including FM systems

3) Cochlear implants

The contractor will be responsible for:

a) Pre-cochlear implant evaluation at a Medi-Cal approved Cochlear Implant Center, including audiology testing, speech pathology assessments, psychological assessments, otolaryngological evaluation and team conferences

b) Cochlear implant surgery, when recommended by a Medi-Cal approved Cochlear Implant Center

c) Post-cochlear implant services, including implant orientation, implant mapping and processor programming, speech perception tests, audiological sound field tests, test assistant, interval speech and language evaluations and aural/oral rehabilitation services.

d) Cochlear implant replacement parts and batteries

e) Cochlear implant speech processor upgrades

q. Medical Nutrition Therapy

The contractor shall be responsible for medical nutrition therapy, by a registered dietitian, that includes nutritional assessment and the development and implementation of a therapy plan.

r. Vision Care, including lenses

The contractor will be responsible for eye examinations, including refraction, eyeglasses, contact lenses, low vision aids, prosthetic eyes and other eye appliances. Shatter resistant eyewear will be provided when there is absence of vision in one eye or one eye is absent.

s. Mental Health

1) The contractor shall be responsible for:

a) Outpatient mental health services that are within the scope of practice of Primary Care Physicians,

b) Prescription drugs (including psychotherapeutic drugs) and

c) Related outpatient laboratory services to treat a diagnosis of mental illness when the services are prescribed by contracting providers or non-psychiatric, non-contracting providers.

2) The contractor shall develop policies and procedures defining the services that are to be provided by Primary Care Physicians.

3) Contractor shall also responsible for outpatient mental health services when the services are provided by non-contracted or contracted psychiatric providers for treatment of a diagnosis that is not covered by the local Medi-Cal County Mental Health Plan.

4) All outpatient laboratory and radiology services when these services are necessary for the diagnosis, monitoring, or treatment of a enrolled child or youth's mental health condition.

5) The contractor shall develop and implement a written internal policy and procedure to ensure that enrolled children and youth who need specialty

mental health services (services outside the scope of practice of Primary Care Physicians) are referred to an appropriate mental health provider and pay for those services, or, refer members to the local mental health plan for specialty mental health services.

6) Contractor shall establish and maintain mechanisms to identify Members who require non-covered psychiatric services and ensure appropriate referrals are made to the local Medi-Cal County Mental Health Plan. If psychiatric services are required for a diagnosis that is not covered by the local Medi-Cal County Mental Health Plan, Contractor shall cover and pay for those services. Contractor shall continue to cover and ensure the provision of primary care and other services unrelated to the mental health treatment and coordinate services between the Primary Care Provider and the psychiatric service provider(s).

t. Comprehensive Perinatal Services

u. Investigational Services, as defined in Title 22 CCR Section 51056.1(b)

v. Out-of-State Services

The contractor will be responsible for out-of-state care when:

a) The medically necessary care is not available within the State of California; or

b) There is an emergency arising from accident, injury, or illness.

4. Payment for the following services is excluded from the responsibility of the contractor:

a. Local Education Agency (LEA) services

b. CCS Medical Therapy Program (MTP) services at CCS MTUs

c. Drug and Alcohol Services

e. Home and Community Based Waiver Services, including the Pediatric Palliative Care Waiver

f. Specialty Mental Health Services

g. Long-Term Institutional Care

h. Experimental Services, as defined in Title 22, CCS, Section 51051.1(a)

i. Equipment to modify home

j. Dental Services

Dental services, except when those services are provided by a CCS approved physician as part of the correction of a craniofacial anomaly.

k. Heart, Liver, Lung, Small Bowel and Bone Marrow Transplants

The costs associated with hospital stays for a heart, lung, combined heart and lung, liver, small bowel, combined liver and small bowel, combined liver and kidney, or bone marrow transplantation, including related inpatient physician services, pharmaceuticals, laboratory services, radiologic studies and organ acquisition or organ donor registry search costs.

k. Acupuncture

l. Chiropractic

D. System Requirements

1. Health Education

a. The contractor shall implement and maintain a health education system that includes programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all enrollees in the Pilot Project.

b. The contractor shall ensure administrative oversight of the health education system by a qualified health educator. This individual shall possess a master's degree in public or community health with specialization in health education.

c. The health education system shall:

1) Use educational strategies and methods that are appropriate for enrolled children and youth and their families and effective in achieving behavioral change for improved health.

2) Ensure that health education materials are written at the sixth grade reading level and are culturally and linguistically appropriate for the enrolled children and youth and their families.

3) Provide educational interventions addressing, at a minimum, the following health categories and topics:

a) Appropriate use of health care services, including preventive and primary health care; and, complimentary and alternative care.

b) Risk-reduction and healthy lifestyles – tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases; HIV and unintended pregnancy; nutrition, weight control, and physical activity; and, parenting.

c) Self-care and management of health conditions specific to the enrollees in the Pilot Projects.

d. The contractor shall periodically review the health education system to ensure appropriate allocation of health education resources, and maintain documentation that demonstrates an effective Quality assurance/quality improvement program

2. Utilization Management/Utilization Review

a. Utilization Management (UM)

The contractor shall develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of medical care services. Specific responsibilities include:

1) Ensuring that qualified professional staff is responsible for the UM program.

2) Ensuring the separation of medical decisions from fiscal and administrative management to assure those medical decisions will not be unduly influenced by fiscal and administrative management.

3) Ensuring that the UM program allows for a second opinion from a qualified health professional.

4) Establishment of criteria for approving, modifying, deferring, or denying requested services with documentation of the manner in which providers are involved in the development and or adoption of specific criteria.

5) Communication to network providers of the procedures and services that require prior authorization and ensure that all health care practitioners are aware of the procedures and timeframes necessary to obtain prior authorization for these services.

6) Development of specialty referral system that tracks and monitors referrals requiring prior authorization and includes authorized, denied, deferred, or modified referrals, and the timeliness of the referrals.

b. Pre-Authorizations and Review Procedures

1) The contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:

a) Qualified health care professionals supervise review decisions and a qualified CCS approved physician will review all denials.

b) There is a set of written criteria or guidelines for Utilization Review that is based on standards of clinical practice for children and youth with CCS eligible medical conditions, is consistently applied, regularly reviewed, and updated.

c) Reasons for decisions are clearly documented.

d) Notification to Members regarding denied, deferred or modified referrals is made as specified in Section TBD. Enrolled children and youth and their families and providers shall be advised of the appeals procedures.

e) Decisions and appeals are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services.

f) Prior Authorization requirements shall not be applied to Emergency Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

g) Records, including any Notice of Action, shall meet the retention requirements of state law.

2) Contractor must notify the requesting provider of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider may be orally or in writing.

c. Timeframes for Medical Authorization

1) Emergency Care: No prior authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency.

2) Post-stabilization: Response to request within 30 minutes or the service is deemed approved.

3) Non-urgent care following an exam in the emergency room: Response to request within 30 minutes or deemed approved.

4) Concurrent Review of authorization for treatment regimen already in place: 72 hours or consistent with urgency of the member's medical condition in accordance with Health & Safety Code Section 1367.01, or any future amendments thereto.

5) Retrospective review: Within 30 days in accordance with Health & Safety Code Section 1367.01, or any future amendments thereto.

6) Pharmaceuticals: 24 hours on all drugs that require prior authorization in accordance with Welfare & Institutions Code, Section 14185 or any future amendments thereto.

7) Routine authorizations: Five (5) business days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health & Safety Code, Section 1367.01, or any future amendments thereto, but, no longer than 14 days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

8) Expedited authorizations: Three (3) working days after receipt of the request for service (these are requests in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function). The time limit may be extended by up to 14 calendars days if the Member requests an extension, or if the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

9) Hospice care: 24 hour response.

d. Review of Utilization Data

Contractor shall include within the UM program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Member utilization patterns shall be reported to DHCS upon request.

3. Care Coordination

a. Each contractor will implement a medical home model based on the principles outlined in **Section TBD.** The contractor will ensure care coordination at two levels – one by the child or youth's designated personal physician and the second by health plan care coordinators.

b. The contractor will provide support to the medical home by providing care coordination services, chronic care management and disease management services that support the personal physician and the child or youth and family. Care coordination activities will include providing assistance to families needing social services and coordination with other program supports such as the MTP Program. Referral and active coordination with disease management programs appropriate to a child or youth's condition(s) will be provided with a "whole child" focus.

c. Each contractor will implement a medical home model based on the principles outlined in Section **TBD**. Each child or youth in the Pilot Project will be assigned to a personal physician, who with the supports provided by the contractor, will function as the child's medical home. Physicians that may serve as a child or youth's personal physician, include family physicians, specialty physicians, or qualified sub-specialty physicians appropriate to the child's condition.

d. The medical home is responsible, working with the contractor's care coordinators, for the development of an individual plan of care that will serve as the basis for ensuring enhanced access to timely and appropriate services across the entire continuum of care and providing family-centered care coordination services. Utilization management and care coordination will be performed by the medical home, utilizing the services and guidelines established by the contractor.

e. It is the responsibility of the medical home to stay apprised of all condition-related services and assure appropriate coordination of those services. The medical home is responsible for assuring that the child receives needed services timely and in an appropriate setting.

f. Each child or youth in the plan will select a personal physician.

The personal physician will be a primary care physician, a specialty physician or sub-specialty physician, who will be responsible for ensuring enhanced access to timely and appropriate services. If a child or youth or parent/legal guardian does not select a personal physician, the plan will assign a personal physician based on past history, provider's experience with the child or youth's specific disease, disability and/or special needs, and the location of the child or youth's home and the provider's office. The personal physician will be responsible for overseeing all of a child or youth's health care needs and for ensuring care is coordinated across the continuum. The personal physician will work in collaboration with EPCCM coordinators to carry out these responsibilities.

g. The plan will be contractually required to provide specialized care coordination for each member.

1) In addition to supporting care coordination provided by the personal physician, the contractor will provide care coordinators to work in partnership with the personal physician and others to ensure the member's care is coordinated and well managed.

2) The contractor will utilize the initial health assessment to determine the level of health plan care coordination required. All care coordinators should have experience working with children and youth with special health care needs or be under the supervision of individuals with experience working with children or youth with special health care needs. Care coordination for children or youth with special health care needs includes both face-to-face and telephone contacts.

The initial assessment will also help inform the choice of an appropriate medical home for the child and ensure continuity of care and services and a smooth transition from fee-for-service to the Pilot Project.

3) A care coordinator will be responsible for the following key functions:

a) Assessment of a child or youth's medical, behavioral, social and functional needs;

b) Development and implementation of a family-centered care plan in collaboration with the medical home provider;

c) On-going monitoring and evaluation, including re-assessments upon a change in condition or status;

d) Coordination of care among systems and providers;

e) Member education and advocacy;

f) Referral into disease and chronic care management programs, ongoing monitoring of the child or youth's status in these programs and coordination and linkage with or to other appropriate providers or resources; and

g) Making referrals and ensuring authorization of services.

h) transition planning

4) In the ACO model, the care coordinator(s) shall be integral members of the SCC team.

5) However, while the contractor may not be financially responsible for a range of special services, such as those provided through Regional Centers, Home and Community Based Services (HCBS) waiver services, behavioral health, medical therapy through the MTP, residential and institutional care services and dental services, the contractor will be responsible for ensuring coordination of all the care the enrolled child or youth receives.

4. Mental Health

The contractor shall develop an MOU with the local mental health plan (MHP) defining the respective responsibilities of Contractor and the MHP in delivering medically necessary covered services and specialty mental health services to children and youth enrolled in the Pilot Project. The MOU shall address:

a. Protocols and procedures for referrals between Contractor and the MHP;

b. Protocols for the delivery of Specialty Mental Health Services, including the MHP's provision of clinical consultation for enrolled children and youth treated by network providers for mental illness;

c. Protocols for the delivery of mental health services within the Primary Care Physician's scope of practice;

d. Protocols and procedures for the exchange of Medical Records information, including procedures for maintaining the confidentiality of Medical Records;

e. Procedures for the delivery of medically necessary covered services to enrolled children and youth who require specialty mental health services, including:

1) Pharmaceutical services and prescription drugs;

2) Laboratory, radiological and radioisotope services;

3) Emergency room facility charges and professional services;

4) Emergency and non-emergency medical transportation;

5) Home health services;

6) Medically Necessary Covered Services to Members who are patients in psychiatric inpatient hospitals.

f. Procedures for transfers between inpatient psychiatric services and inpatient medical services to address changes in a Member's medical or mental health condition.

g. Procedures to resolve disputes between Contractor and the MHP.

5. Enrollees with Developmental Disabilities

a. Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers in order to coordinate services for children and youth enrolled in the Pilot Project who have developmental disabilities.

b. Contractor shall develop and implement procedures for the identification of Members with developmental disabilities.

c. Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall participate with Regional Center staff in the development of the individual developmental services plan required for all persons with developmental disabilities, which includes identification of all appropriate services, including medical care services, which need to be provided to the Member.

d. Services provided under the Home and Community-Based Services (HCBS) waiver programs to persons with developmental disabilities are not covered under this Contract. Contractor shall implement and maintain systems to identify Members with developmental disabilities who may meet the requirements for participation in this waiver and refer these Members to the HCBS Waiver program administered by the State Department of Developmental Services (DDS).

e. If DDS concurs with the Contractor's assessment of the Member and there is available placement in the waiver program, the Member will receive waiver services while enrolled in the plan. Contractor shall continue to provide all Medically Necessary Covered Services.

6. Early Intervention Services

Contractor shall develop and implement systems to identify children who may be eligible to receive services from the Early Start program and refer them to the local Early Start program. These children would include those with a condition known to lead to developmental delay, those in whom a significant developmental delay is suspected, or whose early health history places them at risk for delay. Contractor shall collaborate with the local Regional Center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start program, with Primary Care Provider participation.

7. Local Education Agency Services

Local Education Agency (LEA) assessment services are services specified in Title 22, CCR Section 51360(b) and provided to students who qualify based on Title 22, CCR, Section 51190.1. LEA services provided pursuant to an Individual Education Plan as set forth in Education Code, Section 56340 et seq. or Individual Family Service Plan as set forth in Government Code, Section 95020, are not covered under this Contract. However, the Contractor is responsible for providing a "medical home" and all Medically Necessary Covered Services for the Member, and shall ensure that the Member's primary care physician takes an active role in the development of the Individual Education Plan or the Individual Family Service Plan. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the Individual Education Plan developed by the LEA, with Primary Care Provider participation.

8. Dental Services

a. Dental services are not covered under this Contract. Contractor shall cover and ensure that dental screenings for all Members are included as a part of the initial health assessment. For Members under twenty-one (21) years of age, a dental screening/oral health assessment shall be performed as part of every periodic assessment, with annual dental referrals made commencing at age 3 or earlier if conditions warrant. Contractor shall ensure that Members are referred to appropriate Medi-Cal dental providers.

b. Contractor shall cover and ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists.

c. Covered medical services include: contractually covered prescription drugs; laboratory services; and, pre-admission physical examinations required for admission to an out-patient surgical service center or an in-patient hospitalization required for a dental procedure (including facility fees and anesthesia services for both inpatient and outpatient services).

d. Contractor may require Prior Authorization for medical services required in support of dental procedures.

9. Medical Records

a. The contractor shall develop, implement and maintain written procedures pertaining to any form of medical records:

1) For storage and filing of medical records including: collection, processing, maintenance, storage, retrieval identification, and distribution.

2) To ensure that medical records are protected and confidential in accordance with all Federal and State law.

3) For the release of information and obtaining consent for treatment.

4) To ensure maintenance of medical records in a legible, current, detailed, organized and comprehensive manner (records may be electronic or paper copy).

b. Contractor shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each practice site.

c. Contractor shall ensure that a complete medical record that reflects all aspects of patient care, including ancillary services, is maintained for each Member in accordance with Title 22, CCR, Section 56310 and Title 28, CCR, Section1300.67, and at a minimum includes:

1) Member identification on each page; personal/biographical data in the record.

2) Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services.

3) All entries dated and author identified; for member visits, the entries shall include at a minimum, the subjective complaints, the objective findings, and the plan for diagnosis and treatment.

4) The record shall contain a problem list, a complete record of immunizations and health maintenance or preventive services rendered.

5) Allergies and adverse reactions are prominently noted in the record.

6) All informed consent documentation, including the human sterilization consent procedures required by Title 22, CCR, Sections 51305.1 through 51305.6, if applicable.

7) Reports of emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions.

8) Consultations, referrals to specialists, pathology, and laboratory reports. Any abnormal results shall have an explicit notation in the record.

9) Health education behavioral assessment and referrals to health education services. For patients 12 years or older, a notation concerning use of cigarettes, alcohol, and substance abuse, health education, or counseling and anticipatory guidance.

E. Rights and Responsibilities of Enrolled Children and Families

1. General

a. The contractor shall demonstrate a commitment to treating enrolled children and youth and their families in a manner that acknowledges their rights and responsibilities including, but not limited to:

1) A system which acknowledges racial, ethnic, cultural, linguistic and socioeconomic diversity.

2) Support of family and professional collaboration in all facets of care.

3) Enrolled child and youth/family participation ion the development of an individualized health plan.

4) Education and training of the enrolled child/family to increase their ability to make informed choices and to become more knowledgeable, skilled and confident in their roles.

b. The contractor shall be responsible for informing the enrolled child/family of both their rights and responsibilities, including, but not limited to:

1) Following through with recommendations and health care regimens which have been agreed upon by both the family and professional staff.

2) Following appointment schedules.

3) Providing accurate and complete information about the enrolled child or youth.

4) Requesting clarification of issues involving the enrolled child's care as needed.

5) Accessing appropriate health care services that meet CCS standards/guidelines.

6) Filing a grievance or requesting a fair hearing when services are denied or not appropriate.

2. Grievances

a. The contractor shall establish and maintain written procedures for the submittal, processing and resolution of all child or youth/family grievances and complaints and shall:

1) Operate according to its written procedures, which shall be approved in writing by DHCS prior to use, as shall any amendments.

2) Be described in information sent to each family within seven days of the date of enrollment into the plan and annually thereafter. The description shall include:

a) An explanation of the contractor's system for processing and resolving grievances.

b) A statement that grievance forms are available in the office of each primary physician/primary provider or in the member services office.

c) A statement that grievances may be filed in writing or verbally directly with the contractor or within any office of the contractor's providers.

d) The local or toll-free telephone number a family may call to obtain information about the grievance procedure, request grievance forms and register a verbal grievance.

e) A written statement explaining the family's right to request a fair hearing.

b. The contractor shall make local or toll-free telephone service available to families during normal business hours for requesting grievance forms, filing verbal grievances and requesting information.

c. The contractor shall provide upon request a grievance form, either directly or by mail, if mailing is requested, to any family requesting the form.

d. The contractor shall provide assistance to any family requesting assistance in completing the grievance form.

e. The contractor shall, at a minimum, provide for:

1) Recording in a grievance log of each grievance received b the contractor, either verbally or in writing. The log shall include the following:

a) Date and time the grievance is filed with the contractor or provider.

b) Name of the child and family filing the grievance.

c) Name of provider or staff person receiving the grievance.

d) A description of complaint or problem.

e) A description of the action taken by the contractor or provider to investigate and resolve the grievance.

f) The proposed resolution by contractor or provider.

g) Name of provider or staff person responsible for resolving the grievance.

h) Date of notification of family regarding the proposed resolution.

i) An annotation if family filed for a fair hearing, date of such filing, the date of the adjudication of the fair hearing and a synopsis of the determination resulting from the adjudication.

2) Immediate submittal of all medical quality of care issues to the medical director for action.

3) Submittal, at least quarterly, of all family grievances to the QIC for review and appropriate action, for grievances related to access to care, quality of care and/or denial of services.

4) Review and analysis, on at least a quarterly basis, of all recorded grievances related to access to care and denial of services, and the initiation of action to remedy any problems identified in such reviews.

5) Mailing of a written notice of the proposed resolution to the family that includes information about the family's right to request a fair hearing.

6) System for addressing any cultural or linguistic requirements related to the processing of member grievances.

7) A procedure for expedite review and disposition of grievances in the event of a serious or imminent health threat to a child, in accordance with Health and Safety Code 1368 and 1368.02

f. Grievance forms shall be available in the offices of each of the primary providers, or in the member services department of the contractor.

g. The contractor shall adhere to the following requirements and time frames in processing grievances:

1) Grievances shall be resolved within 30 days of the enrolled child's family submittal of a written or verbal grievance.

2) In the event resolution is not reached within 30 days, the enrolled child's family shall be notified in writing within 30 days by the contractor of the status of the grievance and shall be provided with an estimated completed date for resolution of the grievance.

3) Such notice shall include a statement that the enrolled child's family may exercise its right to request a fair hearing.

h. The contractor shall maintain in its files copies of all grievances, the responses to them and the date the grievance was filed.

i. The contractor shall report to DHCS, in summary form, on a quarterly basis all grievances filed by families of enrolled children pursuant to this provision and the manner in which each grievance is resolved.

j. Submission of a grievance shall not be construed as a waiver of the child's family's right to request a fair hearing.

3. Denial or Modification of Services

a. The contractor shall establish and maintain written procedures to provide each enrolled child's family with a notice of any action taken by the contractor

to deny a request by a provider for authorization of any medical services for the enrolled child.

b. The written notice of action issued pursuant to this subsection shall be mailed within seven days of the decision and shall specify:

1) Action taken by the contractor.

2) The reason for the action taken.

3) A citation of the specific contract provision, statute or regulation that supports the action.

4) The notice shall advise the enrolled child's family of:

a) The right to a fair hearing.

b) The method by which such a hearing shall be obtained.

c) The family's right to be self-represented or be represented by an authorized third party such as legal counsel, relative, friend or any other person.

d) The time frame for requesting a fair hearing.

4. Rights to a Fair Hearing

a. The contractor is responsible for ensuring written procedures are in place to inform the enrolled child's family of its right to a fair hearing conducted by the State in the event that a complaint/grievance is not resolved to their satisfaction. The contractor shall inform each enrolled child's family in writing of their right within seven days of the date of the enrollment in the Pilot Project and annually thereafter.

b. Written notification shall be sent to the enrolled child's family within seven calendar days of the decision by the contractor if there is a denial, deferral or modification of a request for a health care service requiring prior authorization.

F. Enrollment

1. EPCCM, ACO and Specialty Health Care Plan Models

The State and County CCS programs and the Pilot Project contractors will have a joint responsibility for performing outreach activities to identify children who may qualify for CCS and the Pilot Projects, in particular. Outreach activities for the Pilot Projects will include development of materials describing the each of the Pilot Projects, eligibility for the model, how the model will work, how to access care through the model, special features of the model and contact information for the specific Pilot Project.

County CCS programs will determine if a CCS-eligible child or youth meets the criteria to be in the EPCCM, ACO or Specialty Health Care Pilot Project. If the child or youth is eligible, the County will inform the family and child or youth about the Pilot Project, provide descriptive materials of the specific model and enroll the child or youth into the ACO. The County will transmit enrollment information to the contractor and to the state.

All outreach activities and materials will be culturally and linguistically appropriate for children and their family members.

2. Medi-Cal Managed Care Plan Model

A Medi-Cal managed care plan that has a contract for a Pilot Project must implement policies and procedures to identify Medi-Cal beneficiaries who are children and youth with special health care needs that may be eligible for CCS covered services at time of enrollment into the health plan and on a regular periodic basis thereafter. When a child or youth has been identified as with a CCS eligible medical condition, the health plan has the responsibility for referral to the County for confirmation to ensure identification is appropriate.

CCS clients, either those who are Healthy Families subscribers or CCS-only will be referred to the health plan by the CCS program.

G. Quality Monitoring and Improvement Measures

Each of the Pilot Projects will be required to participate in state-led collaborative Quality Improvement Projects (QIPs) during the course of the contract.

Development of the focus of each of the QIPs will be done collaboratively with representatives from each of the Pilot Projects, including administrators, network physicians and families.

H. Data Reporting and Management Information System (MIS)

1. MIS Capability

   a. Each contractor's MIS shall have the capability to capture, edit, and utilize various data elements for both internal management use as well as to meet the data quality and timeliness requirements of DHCS's encounter data submission.

   b. The contractor shall have and maintain a MIS that provides, at a minimum:

      1) All eligibility data,

      2) Information on children and youth enrolled in the Pilot Project.

      3) Provider claims status and payment data,

      4) Health care services delivery encounter data,

      5) Provider network information, and

      6) Financial information as specified in **Section TBD**

   c. The MIS shall have processes that support the interactions between Financial, Member/Eligibility; Provider; Encounter Claims; Quality Management/Quality Improvement/Utilization; and Report Generation subsystems. The interactions of the subsystems must be compatible, efficient and successful.

2. Encounter Data Submittal

   a. Each contractor shall implement policies and procedures for ensuring the complete, accurate, and timely submission of encounter data for all services for which Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements. Encounter data shall include data elements specified in Attachement XX (TBD).

   b. Each contractor shall require subcontractors and non-contracting providers to provide service level data to the contractor, which allows the contractor to meet its administrative functions and the requirements set forth in this section. Contractor shall have in place mechanisms, including edits and reporting systems sufficient to assure service level data is complete and accurate prior to submission to DHS.

   c. Contractor shall submit encounter data to DHS on a monthly basis in the form and manner specified in Attachment XX (TBD).

d. Upon written notice by DHS that the encounter data is insufficient or inaccurate, Contractor shall ensure that corrected data is resubmitted within fifteen (15) days of receipt of DHS' notice. Upon Contractor's written request, DHS may provide a written extension for submission of corrected encounter data.

3. MIS/Data Correspondence

Upon receipt of written notice by DHCS of any problems related to the submittal of data to DHCS, or any changes or clarifications related to Contractor's MIS system, Contractor shall submit to DHCS a Corrective Action Plan with measurable benchmarks within thirty (30) calendar days from the date of the postmark of DHCS' written notice to Contractor. Within thirty (30) days of DHCS' receipt of Contractor's Corrective Action Plan, DHCS shall approve the Corrective Action Plan or request revisions. Within fifteen (15) days after receipt of a request for revisions to the Corrective Action Plan, Contractor shall submit a revised Corrective Action Plan for DHCS approval.

4. Health Insurance Portability and Accountability Act of 1996 (HIPAA) Readiness

The Contractor shall comply with the provisions of Exhibit G, Health Insurance Portability and Accountability Act (HIPAA); 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information and Security Standards for the Protection of Electronic Protected Health Information; Section 41510.4 of Title 22 California Code of Regulations; and all other State Statutes and Regulations on the privacy and security of protected health information and personal confidential information currently in effect or as they become effective.

I. Administrative Responsibilities

1. Legal Capacity

a. The applicant shall have a legally constituted governing body, an appropriate administrative structure and a qualified administrative team that will enable it to carry out the functions for which it is contractually liable.

b. Each applicant must have the legal capacity to enter into a contract with DHCS and shall be appropriately licensed by the State of California, if required by the RFA for the demonstration model for which it is applying. Any contract(s) awarded to an applicant as a result of the applicant's application made pursuant to this RFA will identify the applicant as the "Pilot Project", which shall assume all rights and responsibilities attendant thereto. The Pilot Project shall maintain the legal capacity to contract with DHCS and maintain any licensure, as specified in this RFA.

c. The applicant shall, based on relevant prior experience in the performance of work similar to that describe in this RFA, be able to demonstrate the capability to perform all elements of the work. The prior experience shall consist of and demonstrate both the medical and the administrative abilities to perform such work either by the applicant or the applicant's subcontractor(s). If these demonstration requirements are to be met by the experience of subcontractors, documentation of the subcontractors' experience and ability shall be submitted as part of the applicant's response.

d. Applicants shall demonstrate to DHCS that they possess appropriate financial capability and experience to undertake the provision of health care services identified in this RFA.

2. Governing Body

Each contractor shall have an accountable governing body that shall be committed to supplying any necessary resources to assure full performance under the contract.

3. Advisory Board

Each contractor shall establish a Pilot Project Advisory Board (PPAB) with a minimum of nine representatives included CCS approved health care professionals, advocacy groups and parents of children with a CCS eligible medical condition.

The purpose of the PPAB is to provide advice on the development, implementation and ongoing activities of the Pilot Project. Family representatives must equal at least one-third of the total membership of the PPAB ad shall also function as members of a family sub-committee to encourage active and ongoing participation of parents and other family members in the development and implementation of a family-centered health care delivery system. To the extent possible, selection of family representatives to PPAB should reflect the cultural, educational and socio-economic background of the families proposed to be served through the Pilot Project.

a. Written plan

The contractor must develop and maintain a written plan, approved by DHCS, which provides a detailed description of the responsibilities and operation of PPAB, including the family subcommittee. At a minimum, the plan must include the following:

1) The intended composition of PPAB, the number of members and the criteria and process for selection.

2) The roles, responsibilities and authority of PPAB, particularly in relation to the administrative body of the Pilot Project.

3) The mechanisms for linking PPAB with the family subcommittee and families of children enrolled in the plan for purposes of identifying issues for discussion and/or action, disseminating information, and eliciting feedback related to consumer experiences.

b. Roles and responsibilities

The contractor must allow for ongoing input on and evaluation of polices, procedures and the operation of the Pilot Project by the PPAB in relation to the following:

1) Access to care, including information on the number and nature of requests for services; criteria and processes for authorization or denial of services and appeal mechanisms, procedures and outcomes.

2) Care delivery, including utilization patterns, system efficiency and quality of care, including incorporation of family-centered philosophy into provider/staff training.

3) Evaluation of care, including policies and protocols of the QIP, mechanisms for soliciting family feedback.

c. Family Subcommittee

The subcommittee, consisting of a minimum of seven members, will serve as a vehicle for communication and collaboration between the members of the PPAB and the parents and other family members of children enrolled in the Pilot Project. The purpose of the subcommittee shall be to encourage and facilitate the active participation of families of children enrolled in the Pilot Project in a family-centered system of health care.

4. Administrative Team

The administrative team shall include, at a minimum:

a. Administrator

There shall be a full-time administrator with experience in health care management who will assume the overall responsibility for the day-to-day management of the Pilot Project, including staff, personnel performance and fiscal oversight.

b. Medical Director

1) Each Pilot Project shall have a full-time medical director, a CCS approved pediatrician, pediatric specialist or pediatric subspecialist, whose medical and administrative responsibilities shall consist only of those associated with the Pilot Project. The medical director shall:

   a) Ensure that medical decisions are rendered by qualified medical personnel, without regard to fiscal considerations.

   b) Develop medical policies and procedures for the delivery of health care that are consistent with CCS program standards.

   c) Develop policies and procedures for the credentialing of network individual providers and facilities.

   d) Ensure that medical polices and procedures are implemented and followed.

   e) Develop and implement a system to resolve medically related grievances from providers and/or clients and families.

   f) Develop, implement and provide on-going management of the QIP.

   g) Develop, implement and provide on-going management of the UR system.

   h) Ensure compliance with all state and local reporting statutes and regulations on communicable disease and child abuse and neglect.

   i) Develop and implement training of Pilot Project staff in:

      i. CCS program provider standards

      ii. Pilot Project's medical policies and procedures, including care coordination and case management activities

      iii. Pilot Project's policies and procedures on the Medical Home

      iv. Family-centered care and the role of the clients and families in decision making.

2) Develop and implement training of Pilot Project network providers

   a) CCS program provider standards

b) Pilot Project medical policies and procedures, including care coordination and case management activities

c) Medical Home assignments and responsibilities

d) Family-centered care and the role of the clients and families in decision making

3) Provide oversight and review of all medical care provided.

4) Participate in the monitoring, investigating and hearing of grievances.

5) Have lead responsibility in leading the Pilot Project's participation in quality improvement activities, including participation with other Pilot Project medical directors in developing**……**

c. Director of Care Coordination

1) Each pilot project shall have a full time Director of Care Coordination, who meets the following qualifications:

a) Current licensure as an RN in California

b) Masters Degree in nursing or health related field

c) Minimum of three years of management experience

d) Relevant experience with children and youth with special health care needs, as well as experience with care coordination, utilization review, insurance authorization, regulatory compliance, and quality monitoring

2) The responsibilities of the Director of Care Coordination shall include:

a) Supervision of the Care Coordinators

b) Development and implementation of the policies and procedures for the Care Coordinators

c) Participation in utilization review activities

d) Serving as a quality improvement team member

d. Parent Liaison

The Pilot Project will employ or contract with a parent of a child or youth with a chronic CCS eligible medical condition. The parent will provide consultation

to the Project's administration and care coordinators as well as work with the PPAB and its family subcommittee.

e. Social Worker

The Pilot Project will employ or contract with a social worker to provide consultation to the Project's provider network and the care coordinators.

The social worker shall:

1) Possess a Master's degree in Social Work,

2) Be a Licensed Clinical Social Worker and

3) Have at least two years of experience providing social work services to children and youth with special health care needs.

f. Nutritionist

The Pilot Project will employ or contract with a nutritionist to provide consultation to the Project's provider network and to the care coordinators.

The nutritionist shall:

a) Possess a Master's Degree in Nutrition, Dietetics, Institutional Management, Public Health Nutrition or other nutrition field;

b) Possess a valid certificate of registration with the Commission of Dietetic Registration of the American Dietetic Association; and

c) Have at least two years of full-time or equivalent clinical nutrition experience providing nutrition assessment and counseling for children and youth with special health care needs.

5. Administrative Structure

The Pilot Project shall have as part of its administrative structure the capability to carry out the duties and responsibilities required under the contract which shall include at a minimum:

a. A Management Information System that can capture and report data sufficient to provide specified reports on a timely basis in order to enable ongoing monitoring and evaluation by DHCS.

b. The maintenance of financial records and books of accounts maintained on an accrual basis, in accordance with Generally Accepted Accounting

Principles which fully disclose the disposition of all Pilot Project funds, including payment for services to contracted providers.

c. Membership and enrollment reporting systems as specified by DHCS.

d. A medical record system maintained in a consistent, confidential and organized manner, with designated persons, qualified by training or experience, responsible for the system.

J. Financial Responsibilities - Enhanced Primary Care Case Management Model

1. Financial Viability/Standards Compliance

Contractor shall meet and maintain financial viability/standards compliance to DHCS's satisfaction for each of the following elements:

a. Tangible Net Equity (TNE)

1) Contractor shall, at all times, have and maintain a tangible net equity at least equal to the greater of:

a) $50,000; or

b) The sum of two percent of the first $7,500,000 of annualized premium revenues plus one percent of annualized premium revenues in excess of $7,500,000; or

c) An amount equal to the sum of:

i. Eight percent of the first $7,500,000 of annualized health care expenditures, except those paid on a capitated or managed hospital payment basis; plus

ii. Four percent of the annualized health care expenditures, except those paid on a capitated basis or managed hospital payment basis, which are in excess of $7,500,000; plus

2) For the purpose of this section "net equity" means the excess of total assets over total liabilities, excluding liabilities which have been subordinated in a manner acceptable to the Director.

"Tangible net equity" means net equity reduced by the value assigned to the intangible assets including, but not limited to, good will; going concern value; organizational expense; starting-up costs; obligations of officers, directors, owners, or affiliates which are not fully secured, except short-term obligations of affiliates for goods or services arising in the normal

course of business which are payable on the same terms as equivalent transactions with non-affiliates and which are not past due; long term prepayments of deferred charges, and non-returnable deposits. An obligation is fully secured for the purposes of this subsection if it is secured by tangible collateral, other than by securities of the plan or an affiliate, with an equity of at least 110 percent of the amount owing.

3) For the purpose of this section, "capitated basis" means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities.

4) For the purpose of this section, "managed hospital payment basis" means agreement wherein the financial risk is primarily related to the degree of utilization rather than to the cost of services.

b. Administrative Costs

Contractor's Administrative Costs shall not exceed 15 percent, unless otherwise authorized in writing by DHCS after the submission of appropriate justification by the Contractor.

c. Standards of Organization and Financial Soundness.

Contractor shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations in accordance with Title 28, CCR, Sections 1300.67.3, 1300.75.1, 1300.76.3, 1300.77.1, 1300.77.2, 1300.77.3, 1300.77.4, and Title 22, CCR, Sections 56210, 56251, and 56324.

d. Working capital and current ratio of one of the following:

1) Contractor shall maintain a working capital ratio of at least 1:1; or

2) Contractor shall demonstrate to DHCS that Contractor is now meeting financial obligations on a timely basis and has been doing so for at least the preceding two years; or

3) Contractor shall provide evidence that sufficient noncurrent assets, which are readily convertible to cash, are available to achieve an equivalent working capital ratio of 1:1, if the noncurrent assets are considered current.

2. Financial Audit Reports

Contractor shall ensure that an annual audit is performed according to Welfare & Institution Code, Section 14459. Combined Financial Statements shall be prepared to show the financial position of the overall related health care delivery system when delivery of care or other services is dependent upon Affiliates.

Financial Statements shall be presented in a form that clearly shows the financial position of Contractor separately from the combined totals. Inter-entity transactions and profits shall be eliminated if combined statements are prepared.

If an independent accountant decides that preparation of combined statements is inappropriate, Contractor shall have separate certified Financial Statements prepared for each entity.

a. The independent accountant shall state in writing reasons for not preparing combined Financial Statements.

b. Contractor shall provide supplemental schedules that clearly reflect all inter-entity transactions and eliminations necessary to enable DHCS to analyze the overall financial status of the entire health care delivery system.

1) In addition to annual certified Financial Statements, Contractor shall complete the required financial reporting forms. The Certified Public Accountant's audited Financial Statements and the required financial reporting forms shall be submitted to DHCS no later than 120 calendar days after the close of Contractor's Fiscal Year.

2) Contractor shall submit to DHCS, quarterly financial reports within forty-five (45) calendar days after the close of Contractor's fiscal quarter. The required quarterly financial reports shall be prepared on the required financial reporting forms as defined in Title 28, CCR, Section 1300.84.2, and shall include at a minimum, the following reports/schedules:

a) Jurat.

b) Report 1A and 1B: Balance Sheet.

c) Report 2: Statement of Revenue, Expenses, and Net Worth.

d) Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95 (This statement is prepared in lieu of Report #3: Statement of Changes in Financial Position for Generally Accepted Accounting Principles (GAAP) compliance.)

e) Report 4: Enrollment and Utilization Table.

f) Schedule F: Unpaid Claims Analysis.

g) Appropriate footnote disclosures in accordance with GAAP.

c. Contractor shall authorize its independent accountant to allow DHS designated representatives or agents, upon written request, to inspect any and all working papers related to the preparation of the audit report.

d. Contractor shall submit to DHS all financial reports relevant to Affiliates as specified in Title 22, CCR, Section 53862(c)(4).

e. Contractor shall submit to DHS copies of any financial reports submitted to other public or private organizations as specified in Title 22, CCR, Section 56312(e).

3. Monthly Financial Statements

Contractor and/or sub-contractors may be required to file monthly Financial Statements at DHS' request. The required monthly reports shall be prepared on the required financial reporting forms and shall include at a minimum, the following reports/schedules:

a. Jurat.

b. Reports 1A and 1B: Balance Sheet.

c. Report 2: Statement of Revenue, Expenses, and Net Worth.

d. Report 4: Enrollment and Utilization Table; and

e. Appropriate footnote disclosures in accordance with GAAP 95 (This statement is prepared in lieu of Report #3: Statement of Changes in Financial Position for Generally Accepted Accounting Principles (GAAP) compliance.)

4. Compliance with Audit Requirements

Contractor shall cooperate with DHS' audits.

5. Submittal of Financial Information

Contractor shall prepare financial information requested in accordance with GAAP and where Financial Statements/projections are requested, these statements/projections should be prepared in accordance with the 1989 HMO Financial Report of Affairs and Conditions Format. Where appropriate, reference

has been made to the Knox-Keene Health Care Service Plan Act of 1975 Rules found under Title 28, CCR, Section 1300.51 et. seq. Information submitted shall be based on current operations. Contractor and/or sub-contractors shall submit financial information consistent with filing requirements of the DMHC unless otherwise specified by DHS.

Contractor shall prepare and submit a stand-alone Medi-Cal line of business income statement for each financial reporting period required. This income statement shall be prepared in the DMHC required financial reporting format.

6. Fiscal Viability of Subcontracting Entities

Contractor shall maintain a system to evaluate and monitor the financial viability of all sub-contracting provider groups such as HMOs, independent physician/provider associations (IPAs), medical groups, and Federally Qualified Health Centers.

K. Financial Responsibilities- Accountable Care Organization

L. Specialty Health Care Plan or Medi-Cal Managed Care Model

1. Financial Viability/Standards Compliance

Contractor shall meet and maintain financial viability/standards compliance to DHCS's satisfaction for each of the following elements:

a. Tangible Net Equity (TNE).

Contractor at all times shall be in compliance with the TNE requirements in accordance with Title 28, CCR, Section 1300.76.

b. Administrative Costs.

Contractor's Administrative Costs shall not exceed the guidelines as established under Title 28, CCR, Section 1300.78.

c. Standards of Organization and Financial Soundness.

Contractor shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations in accordance with Title 28, CCR, Sections 1300.67.3, 1300.75.1, 1300.76.3, 1300.77.1, 1300.77.2, 1300.77.3, 1300.77.4, and Title 22, CCR, Sections 53251 and Health and Safety Code, Section 1375.1.

d. Working capital and current ratio of one of the following:

1) Contractor shall maintain a working capital ratio of at least 1:1; or

2) Contractor shall demonstrate to DHCS that Contractor is meeting financial obligations on a timely basis and has been doing so for at least the preceding two years; or

3) Contractor shall provide evidence that sufficient noncurrent assets, which are readily convertible to cash, are available to achieve an equivalent working capital ratio of 1:1, if the noncurrent assets are considered current.

2. Financial Audit Reports

Contractor shall ensure that an annual audit is performed according to Welfare and Institutions Code, Section 14459. Combined Financial Statements shall be prepared to show the financial position of the overall related health care delivery system when delivery of care or other services is dependent upon Affiliates. Financial Statements shall be presented in a form that clearly shows the financial position of Contractor separately from the combined totals. Inter-entity transactions and profits shall be eliminated if combined statements are prepared. If an independent accountant decides that preparation of combined statements is inappropriate, Contractor shall have separate certified Financial Statements prepared for each entity.

a. The independent accountant shall state in writing reasons for not preparing combined Financial Statements.

b. Contractor shall provide supplemental schedules that clearly reflect all inter-entity transactions and eliminations necessary to enable DHCS to analyze the overall financial status of the entire health care delivery system.

1) In addition to annual certified Financial Statements, Contractor shall complete the State Department of Managed Health Care (DMHC) required financial reporting forms. The Certified Public Accountant's audited Financial Statements and the DMHC required financial reporting forms shall be submitted to DHCS no later than 120 calendar days after the close of Contractor's Fiscal Year.

2) Contractor shall submit to DHS within 45 calendar days after the close of Contractor's fiscal quarter, quarterly financial reports required by Title 22, CCR, Section 53862(b)(1) and hereby made applicable to this Contract. The required quarterly financial reports shall be prepared on the DMHC required financial reporting forms and shall include, at a minimum, the following reports/schedules:

a) Jurat.

b) Report 1A and 1B: Balance Sheet.

c) Report 2: Statement of Revenue, Expenses, and Net Worth.

d) Statement of Cash Flow, prepared in accordance with Financial Accounting Standards Board Statement Number 95. (This statement is prepared in lieu of Report #3: Statement of Changes in Financial Position for Generally Accepted Accounting Principles (GAAP) compliance.)

e) Report 4: Enrollment and Utilization Table.

f) Schedule F: Unpaid Claims Analysis.

g) Appropriate footnote disclosures in accordance with GAAP.

h) Schedule H: Aging Of All Claims.

c. Contractor shall authorize its independent accountant to allow DHS designated representatives or agents, upon written request, to inspect any and all working papers related to the preparation of the audit report.

d. Contractor shall submit to DHS all financial reports relevant to Affiliates as specified in Title 22, CCR, Section 53330.

e. Contractor shall submit to DHS copies of any financial reports submitted to other public or private organizations as specified in Title 22, CCR, Section 53324(d).

3. Monthly Financial Statements

   If Contractor and/or subcontractor is required to file monthly Financial Statements with the DMHC, Contractor and/or subcontractor shall file monthly Financial Statements with DHS.

4. Compliance with Audit Requirements

   Contractor shall cooperate with DHS' audits. Such audits may be waived upon submission of the financial audit for the same period conducted by DMHC pursuant to Section 1382 of the Health and Safety Code.

5. Submittal of Financial Information

   Contractor shall prepare financial information requested in accordance with GAAP and where Financial Statements/projections are requested, these statements/projections should be prepared in accordance with the 1989 HMO Financial Report of Affairs and Conditions Format. Where appropriate, reference has been made to the Knox-Keene Health Care Service Plan Act of 1975 rules found under Title 28, CCR, Section 1300.51 et. seq. Information submitted shall be based on current operations. Contractor and/or subcontractors shall submit financial information consistent with filing requirements of the DMHC unless otherwise specified by DHS.

   Contractor shall prepare and submit a stand-alone Medi-Cal line of business income statement for each financial reporting period required. This income statement shall be prepared in the DMHC required financial reporting format.

6. Fiscal Viability of Subcontracting Entities

   Contractor shall maintain a system to evaluate and monitor the financial viability of all risk-bearing subcontracting provider groups, including but not limited to, HMOs, independent physician/provider associations (IPAs), medical groups, and Federally Qualified Health Centers.

M. Reimbursement

N. Evaluation of Pilot Projects

DHCS proposes to use an "intervention and comparison group" design to estimate the effects of the Pilot Projects as they relate to key research questions. An evaluation team will work with DHCS officials and participating pediatric specialists and subspecialists from each of the Pilot Projects to create a comparison group of patients from other regions of the state with similar diagnoses, co-morbidities and annual baseline expenditures who are age- and gender- matched to those patients who are enrolled at the intervention sites. Where measures are not available for the comparison group, a pre- and post-intervention design will be followed. In addition, input will be sought from families and clients in designing measures.

1. Research Questions

   Key questions and examples of potential measures include:

   a. *Did the implementation of the new model demonstrate evidence of improved care coordination?* Potential structural, process and outcome measures could include:

      1) Coordination with the healthcare delivery system (e.g., e-mail, shared electronic medical records, co-located services)

2) Coordination between the healthcare delivery system and community agencies

3) Consistent care coordination, as evidenced by variation in the application of clinical guidelines

4) Comprehensive care coordination, as measured by levels of adherence to clinical guidelines

5) Coordination that is family- and patient-centered, as measured by how families are involved in decision-making

6) Examples of structural, process and outcome measures may include: evidence of an up-to-date treatment plan; evidence of a central record or database containing all pertinent medical information; evidence that referrals to specialty care resulted in a timely visit; evidence of a discharge plan after any hospitalization; follow-up visit to primary care provider occurred within 7 days of discharge; and 30-day readmission rates.

7) Examples of existing tools to facilitate this aspect of the evaluation may include the Medical Home Index (MHI), a nationally validated self-assessment tool that includes measures of care coordination components, such as continuity of care, appropriate use of subspecialty consultation, interaction with school and community agencies, and a central, accessible medical record.

b. *Did the quality of care for children included in the program improve over the course of the demonstration?*

The State will examine improvements in the quality of care from different perspectives, including those of patients and caregivers, and clinical providers. Quality of care as defined by the Institute of Medicine is care that is: safe, timely, effective, efficient, equitable, and patient- and family-centered.

In evaluating the demonstration program's effects on quality of care, the evaluation team will examine clinical and patient-based (patient-reported) outcomes that reflect these dimensions of quality. Clinical outcomes applying to all conditions will include a mix of process and outcome measures such as the following: emergency department visits; inpatient hospital days; number of annual visits to primary care (medical home) provider; return visits to the ED within 7 days; review of any death for possibility of prevention; and measures of growth and development (for younger children and when appropriate).

Clinical outcomes specific to each condition will be established from the literature as well as based on consensus among the condition-specific

pediatric specialists. Patient-based outcomes will include measures of functional status of the child and family (when appropriate), such as days lost from school, or days lost from work, and health-related quality of life measures. Quality of care measures will be drawn, as appropriate, from existing tools such as the PedsQL™ Measurement Model for the Pediatric Quality of Life Inventory, developed by James W. Varni, with the Center for Child Health Outcomes at Children' s Hospital and Health Center in San Diego. The PedsQL™ has several disease-specific modules, including one for cardiac conditions and cancer.

c. *Did the model increase the value of services provided to CYSHCN?*

The evaluation team will work with the State to identify and collect financial data that can measure annual costs for patients enrolled in the demonstration model at baseline, and yearly thereafter, compared to the matched group of non-participating patients. These data will be used to assess the growth rate of expenditures, the mix of services utilized and their proportional costs, as well as the cost-effectiveness of the new model, based on selected patient outcomes data.

d. *Did the model reduce the rate of growth in spending?*

The Evaluation Team will aggregate 3 to 5 years of relevant pre-intervention cost data to develop a baseline from which a trend rate in spending for the post-intervention years can be developed. The differences in costs and rates of growth between the intervention group and the comparison group will be used to approximate the model's financial impact.

e. *Did the model change the distribution of the mix of services utilized by patients targeted in the demonstration?*

The evaluation will compare the totals (per patient) and proportions of baseline and post-intervention costs on major spending categories such as inpatient services, outpatient visits, emergency department visits, diagnostic testing, pharmacy, DME, and HCBS. The analysis will also include examination of total inpatient admissions and average length of stay to understand how observed reductions in inpatient spending were achieved.

f. *Did the model improve the value or cost-effectiveness of care provided to children enrolled in the demonstration?*

The evaluation team expects to develop a cost-effectiveness model to analyze spending relative to improvements in selected health and quality of life outcomes for patients included in the demonstration. Examples of measures to be incorporated into these analyses include cost per child per

year, cost per condition per year, cost per episode of illness per child, and cost per episode per condition.

g. *Did patient, family and provider satisfaction improve over the course of the demonstration?*

Using appropriate survey questions and qualitative analyses, the State expects the evaluation to show that patients and families included in the demonstration model experienced a greater sense of satisfaction after the model's full implementation; that satisfaction among participating providers increased; and that these providers will be interested in continuing the model and suggesting its expansion to other states.

2. Sources of Data

The evaluation plan created during the planning period will identify potentially useful secondary data sources and their collection and reporting period to determine to what extent they contain appropriate elements that can be extracted in a timely manner for baseline and post-intervention reporting and analysis. Examples of datasets would include: Medi-Cal cost and administrative data; California Office of Statewide Health Planning and Development (OSHPD) inpatient discharge data; patient medical records; and patient registries for each condition (to be developed during the planning phase).

The evaluation team will identify and explore the feasibility of primary data collection requirements to answer particular research questions, using existing instruments, such as the MHI and the PedsQL™. The evaluation plan will also identify any new data collection instruments that need to be created to answer specific questions, with an interest in minimizing their use and burden on providers and families.

3. Analyses

For each major evaluation question and subset of questions, the data source(s), research methods and analytical approaches will be defined. At a minimum, and as appropriate, the evaluation team will provide descriptive statistics on key measures of interest. Continuous variables will be characterized by range and mean ± the standard deviation. Specific statistical analyses will be selected that are appropriate to the characteristics of each variable. Where data are sufficiently robust, the evaluation will include sub-group analyses by condition and or institution, or by race/ethnicity. For impact analyses of financial data and health outcomes, multivariate analyses may be used to control for other influencing factors, such as patient age, severity of condition, individual institution, and Medicaid aid code category.

4. Reporting

   The evaluation team will produce a baseline report, annual interim reports and a final evaluation report that: shows cumulative changes, summarizes the evaluation findings related to each major research question, discusses the major strengths and weaknesses of the model from a financial, operational and quality of care perspective, and assesses the feasibility of expanding the model statewide, with recommendations for modifications to improve its effectiveness.

5. Evaluation Requirements for Contractors

   Each Pilot Project shall ensure that all reporting requirements which provide information on specific children enrolled in the Project are fully complied with. This will ensure that encounter/claims information is available for all services which enrolled children will receive.

   Pilot Projects will be asked to assist the evaluators in accessing family members of some of the enrolled children for the purposes of completing surveys and/or in-depth studies.

   Some or all of the children enrolled in a Pilot Project, their families and some or all of the providers that may be part of a Pilot Project's network will be asked to participate in one or more surveys related to the Pilot Project. Such surveys may cover topics such as experiences with access, availability, satisfaction and quality of care received in the Pilot Project. These surveys cold potentially compare these experiences to the experiences encountered prior to the development of the Pilot Projects.

   Pilot Projects may be asked to participate in one or more surveys on a variety of subjects related to the Pilots.

V. RFA APPLICATION

A. Application Process

B. Letters of Intent

C. Applicants' Conference

D. Application Submission Instructions

E. Application Format

F. Application Content

1. General

   All applicants are advised that the submitted application is the only document provided to reviewers upon which evaluation scores will be made. Reviewers are not expected to have additional insight into the capabilities of any applicant or specific information about service networks serving children and youth with CCS eligible medical conditions.

   The applicant must respond to each of the requirements described in this RFA. Responses must be clear, complete and in sufficient detail to provide a comprehensive description of the applicant's existing and proposed system capacity.

   The must include a description of all products, procedures, tools, methodologies, research knowledge, and automated support necessary to perform the scope of work.

   Applicants must demonstrate that they can meet all of the submission requirements of this RFA, regardless of whether the requirements are specifically delineated in the brief descriptions below.

2. Application Content and Order

   a. Transmittal Letter

      The transmittal letter must be on the applicant's official business letterhead and signed by the individual duly authorized to legally bind the applicant in contractual agreements. The transmittal letter must include:

      1) Identification of all materials and enclosures being forwarded in response to this RFA.

      2) The name, address, telephone number, fax number and e-mail address of the designated person to receive communications regarding the application.

      3) A statement indicating the applicant is a corporate or other legal entity.

      4) Identification of the applicant's representative: the individual duly authorized to legally bind the applicant in contractual agreements. This duly authorized individual will be known as the applicant's representative.

      5) State if the applicant is a Knox-Keene licensed entity or a non-Knox-Keene entity.

      6) Federal Tax Identification number.

b. Table of Contents

The transmittal letter must be followed by a Table of Contents. Within the Table of Contents, each section, technical response, attachments and exhibits must be clearly identified and assigned page numbers or tab numbers.

c. Application Checklist

There must be a copy of the application checklist found in Attachment **TBD** which contains a summary of all items, documents and other information required in the submission of the application. The checklist is to be used by DHCS and the applicant to verify inclusion of all submission requirements. Check off each item to indicate that all application requirements are completed and are included in the submission package.

d. Executive Summary

The executive summary is to provide an overview of the applicant's organization and a summary of the application. This is not to exceed two pages in length and should include a brief agency profile, how major elements of the proposed scope of work will be integrated into the applicant's existing structure, the geographic service area to be serviced, and an overview of how the applicant envisions the Pilot Project will meet the needs of eligible children and youth and their families.

e. Pilot Project Narrative Description

1) Describe the applicant's background and experience in serving children and youth with special health care needs and children and youth from families with low incomes in the areas of service delivery, medical case management and care coordination, family-centered care, and in the provision of geographic, physical, cultural and linguistic access.

2) Describe the applicant's efforts to work within its community to establish linkages with relevant provider networks, parent groups, and other organizations in providing services to CYSHCN.

3) Describe how the applicant has communicated and worked with key leaders, organizations/agencies and members of the community in the development and implementation of this Pilot Project.

4) Provide at least five (5) but not more than ten (10) letters of support form agencies/organizations who have and would continue to support,

collaborate, coordinate or strategically plan activities and programs in support of the Pilot Project.

5) For those agencies with which the applicant has a collaborative relationship, state how long the partnership has been in existence and describe prior projects, activities and accomplishments.

f. Geographic Service Area and Potential Sample Size

1) Describe the geographic service area proposed for the Pilot Project and if the service area covers more than one county, describe how this area is consistent with the regionalization of the current service delivery system for children and youth with CCS eligible medical conditions.

2) Describe the potential number of CCS children and youth who will be enrolled in the Pilot Project.

g. Applicant Capability Section

1) Current Organization Profile

Describe the organization that is submitting the application and how the Pilot Project will be incorporated into the organization's administrative structure.

2) Proposed Organization Profile

a) Describe the staffing plan which details sufficient number of staff (medical, professional, administrative and support) for this Pilot Project that will allow the proper performance of the requirements as described in this RFA. Include an organizational chart showing the placement and number of all management and professional staff positions and a job description for each position dedicated to the Pilot Project and specify title, responsibilities, education requirements and salary range. Include resumes of Pilot Project personnel who will exercise major administrative, policy or consulting functions in the work requirements specified in this RFA.

b) Describe how the applicant will ensure that sufficient and qualified staff are recruited and hired to perform the scope of work as specified in this RFA.

c) Applicants who plan to use specialists/consultants and/or subcontractors to conduct any responsibilities under this RFA other than as providers of medical services, must:

i. Identify the name, address and telephone number of each specialist/consultant or subcontractor

ii. Provider letters of agreement from these specialists/consultants or subcontractor

iii. Indicate their proposed availability

iv. Indicate their expertise

v. Describe responsibilities assigned to each under this application

vi. Provide current resumes in the attachments section with appropriate cross-references as indicated

d) Describe how the administrative structure will monitor and evaluate the performance and compliance with contractors and how they will protect the Pilot Project, and its enrollees and providers in the event there is a failure of performance or the contract is terminated.

e) Submit a statement describing how the Pilot Project will provide for separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by fiscal and administrative management. Describe the controls that will be put into place to assure compliance with this requirement.

h. Scope of Work

The applicant shall include full and complete descriptions of how the applicant intends to develop, implement and meet all the requirements contained in **TBD.** In addition, the application must include a proposed work plan, including time and persons responsible for recruiting, hiring, and training of necessary staff and implementing the scope of work. The work plan shall include all Pilot Project activities, contract deliverables, and required reports contained in this RFA.

1) Pilot Project Advisory Board

a) Describe how the PPAB has been and/or will be established and operate to provide advice on the development, implementation and ongoing activities of the Pilot Project. Include a description of the size, composition, roles and responsibilities, anticipated meeting schedules and provisions for communication between the PPAB and the Pilot Project administrative staff, the families served by the Pilot Project and other related entities.

b) Describe the mechanisms by which the Pilot Project will encourage the active involvement and participate of families of children and youth enrolled in the Project on the PPAB and family subcommittee.

2) Family-Centered Care

a) Describe the mechanisms by which the Pilot Project will use to involve and prepare the child or youth's family and/or caregiver as active participants in planning for providing ongoing care of their child or youth.

b) Describe the methods by which the applicant intends to involve families in the system of care, including the specific requirements identified in document and how the issues of time considerations and provider resistance will be addressed.

c) Describe the systems that will be used to ensure that the child or youth's Individual Treatment Plan will be updated and monitored as necessary.

d) Describe how the Pilot Project will evaluate the ongoing implementation of family-centered care and the impact of incorporating families into the ongoing delivery of care.

3) Service Network and Access to Care

a) Describe how the Pilot Project will be organized to ensure that all required services (preventive, primary, specialty, etc) will be provided and accessible to all children and youth enrolled in the Project.

b) Describe the mechanism(s) that the Pilot Project will use to ensure appointment availability and the required time frames for routine, symptomatic, urgent and emergency care are maintained through the Project's network of providers.

c) Provide a detailed description of the provider network that will be used to provide treatment of the full range of medical conditions and provide the comprehensive health care required by the enrolled children and youth. Identify the providers to be used and describe which providers will the employees of the Pilot Project, subcontractors and/or consultants.

d) Provide information as to how the Pilot Project will ensure and control access to providers including those outside the specified geographic service area of the Project.

e) Describe the systems for ensuring that medical and other health care staff are qualified to provide the services required and adequately trained to fulfill their roles and responsibilities.

f) Describe how the Pilot Project plans to provide and maintain a 24/7 telephone access system for medical advice, member services information

g) Describe the methods by which the Pilot Project will use to ensure that services will be accessible to enrolled children and youth and their families. Specifically address how the Pilot Project will eliminate geographic, physical, cultural and linguistic barriers to services.

4) Scope of Services

a) Describe how access to each of the required services will be ensured. Include a discussion of the methodology by which medical necessity for care will be determined and the appropriate level of care will be assured. Indicate, and describe any additional services, not included in the required list of services, which the Pilot Project intends to offer and the rationale for providing the service(s).

b) Describe the system for ensuring that children and youth enrolled in the Pilot Project will be evaluated and referred for medically necessary services which are not included in the Pilot Project's scope of services. Include a discussion as to how each type of referral will be handled, indicating the availability of referral resources and issues of access; how these issues have been and will be addressed; the names, locations and type of referral relationships which have been established; and copies of referral agreements already negotiated.

c) Specifically address how referrals for routine and specialty dental care will be handled and access to appropriate and timely dental care ensured.

5) System Requirements

a) Care Coordination and Medical Case Management

i. Medical Home

A. Describe the mechanisms by which the contractor ensures that each child or youth enrolled in the Pilot Project has a personal physician serving as the medical home and if the child or youth or family has not selected one how the assignment will be made.

B. Describe the mechanisms by which physicians that will be designated as primary care physicians receive information as to their roles and responsibilities as a medical home, including the supports available through the contractor's care coordinators.

C. Describe the mechanisms by which the contractor will ensure that the medical home will complete an individual care plan with family for each enrolled child and youth that meets the requirements of **TBD.**

D. Describe how the contractor will monitor how the personal physicians will be providing access to after hours care.

ii. Care Coordinators

A. Describe the experience and education required of individuals that will work as care coordinators.

B. Describe the mechanisms by which the care coordinators will work with the medical homes and families of enrolled children and youth in development of the individual care plan that addresses the medical, behavioral, social and functional needs.

C. Describe how the care coordinators will monitor and evaluate the enrolled children and youth's ongoing care needs.

D. Describe how enrolled children and youth needing referrals to other systems of care, including the Regional Center, county mental health plan, and the local education agency will be identified, how the referrals will be made and how care will be coordinated with these agencies.

E. Describe how the care coordinators will coordinate, track and monitor the referrals and potential delivery of services.

F. Describe how referral to medically necessary services, not payable by the Pilot Project, will be made, including, but not limited to dental services and HCBS services; also describe how the care coordinators will coordinate, track and monitor the delivery of such services.

G. Describe the processes by which the care coordinators will initiate transition planning for enrollees 14 years of age and older.

iii. Health Education

A. Describe how children and youth enrolled in the Pilot Project and their families will receive health education, health materials and

B. Describe how the contractor will ensure that the health education system is overseen by a qualified health educator and that the health education system is periodically reviewed.

iv. Quality Assurance/QIP

A. Describe the processes that will be implemented to ensure that qualified professional staff is solely responsible for making medical decisions which are not influenced by fiscal and/or administrative management.

B. Describe the processes that will ensure that a second opinion from a qualified health care professional is available.

C. Describe the processes by which criteria will be established for approving, modifying deferring or denying requests for services, including the methodology by which network providers are notified of the criteria.

D. Describe the processes by which referrals in and out of the network are tracked and monitored.

v. Medical Records

A. Describe the system for maintaining medical records including processes and procedures for ensure that documentation is complete (including al RFA requirements), current, legible, secure and retrievable. Include a discussion of which records are maintained centrally and are not; procedures for transferring/communicating information between providers in the network and the Pilot Project administration; polices and procedures for release of medical information to outside entities include family members, referral resources, county CCS programs, DHCS staff and the Pilot Project evaluation team;

procedures for protecting/maintaining confidential information; and monitoring/auditing policies and procedures.

vi. Coordination with State/county CCS and other agencies

Identify the local agencies with which the Pilot Project has established, or intends to establish, a formal collaborative agreement. Attach copies of the written agreements which have been established and approved by both entities, including signature of the authorizing agents.

b) Rights and Responsibilities of Enrolled Children and their Families

i. Describe the complaint/grievance system including the processes for informing enrolled children and youth and their families of their rights and responsibilities; ensuring their access to grievance appeal procedures; documents and communicating information related to grievances, denials of services, appeals, outcomes; resolving grievances and appeals within prescribed time frames; monitoring and evaluation of grievances and of the grievance/appeal system; mechanisms for feedback and correction of problems identified, etc.

ii. Describe how the grievance/appeal system will be structured within the Pilot Project including how oversight and ongoing responsibility will be assigned; and how the lines of authority, responsibility, accountability and communication are defined.

iii. Describe how the Pilot Project will ensure the rights of enrolled children and youth and their families to a fair hearing.

c) Enrollment/Disenrollment

d) Quality Monitoring and Improvement Measures

Describe the mechanisms by which individuals will be designated to represent the contractor in developing and participating I the Quality Improvement collaboratives.

e) Data Reporting and Management Information System

f) Pilot Project Administrative Responsibilities

i. Describe how the governing body of the organization/agency shall be committed to providing the resources necessary to support the Pilot Project in providing the services required in this RFA.

ii. Describe the system that will ensure the medical decisions will be based on current medical practice and standards of care for children and youth with CCS eligible medical conditions.

iii. Submit the names and resumes of the Pilot Project administrator who will assume the overall responsibility for the day-to-day management of the Pilot Project; the medical director who has responsibility for oversight of the medical services and the director of Care Coordination.

6) Financial Information

Each applicant shall submit the financial information requested in Attachment **TBD**

7) Mandatory Document Requirements

8) Application Attachments

List all attachments, along with a brief description of each document. Each attachment should be clearly identified with the Section or Subsection or item to which it applies.